

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

MARICEL MARCIAL)	
)	
Plaintiff,)	Case No. 1:16-cv-06109
)	
v.)	Honorable Susan E. Cox
)	
RUSH UNIVERSITY MEDICAL CENTER,)	
DR. MICHAEL KREMER, in his individual)	
capacity, RAY NARBONE, in his individual)	
capacity, and JILL WIMBERLY, in her individual)	
capacity,)	
)	
Defendants.)	

**PLAINTIFF'S EXHIBITS A15 THROUGH A27 TO REPORT OF
EXPERT WITNESS DR. STEVEN R. FARMILANT**

Pursuant to Federal Rule of Civil Procedure 26(a)(2)(B), and to this Honorable Court's August 30, 2018, Memorandum Opinion, Dkt #101, and its September 10, 2018, Minute Entry Order, Dkt #104, Plaintiff, Maricel Marcial, by her attorneys, Elaine K.B. Siegel & Assoc., P.C., submits the accompanying Plaintiff's Exhibits A15 Through A27 to Report of Expert Witness Dr. Steven R. Farmilant.

DATED: October 4, 2018

Respectfully submitted,

/s/ Elaine K.B. Siegel
One of Plaintiffs' Attorneys

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EXHIBIT

A15

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

MARICEL MARCIAL,)	
)	
Plaintiff,)	
)	
vs.)	No. 16-cv-06109
)	
RUSH UNIVERSITY MEDICAL CENTER;)	
DR. MICHAEL KREMER, in his)	
individual capacity; RAY NARBONE,)	
in his individual capacity; and)	
JILL WIMBERLY, in her individual)	
capacity,)	
)	
Defendants.)	

The deposition of MARICEL MARCIAL, called by the Defendants for examination, pursuant to notice and pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before Erin McLaughlin, CSR, at 120 S. Riverside Plaza, Suite 1100,, Chicago, Illinois, on Wednesday, February 28, 2018, commencing at the hour of 9:30 o'clock a.m.

Reported for
MAGNA LEGAL SERVICES, by
Erin McLaughlin, CSR

Page 2

APPEARANCES:

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MS. ELAINE K.B. SIEGEL,
appeared on behalf of the Plaintiff;

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MR. PETER G. LAND and MS. KAREN L. COURTHEOUX,
appeared on behalf of the Defendant;

ALSO PRESENT:

MR. DAVID RICE;
MR. JOSEPH MENDELSON.

* * * * *

Page 3

I N D E X

THE WITNESS: MARICEL MARCIAL

PAGE

EXAMINATION BY:

MR. LAND 6

EXHIBITS MARKED:

No. 1	6
No. 2	55
No. 3	85
No. 4	100
No. 5	183
No. 6	190

Page 4

(Witness sworn.)

MR. LAND: Good morning. Can you please state your name for the record and spell your last name.

THE WITNESS: My name is Maricel Marcial, M-a-r-c-i-a-l.

MR. LAND: Thank you.

So I'm Pete Land, and I'm an attorney. I represent Rush University Medical Center and the other individually named defendants who are in the lawsuit that you initiated in Federal Court. We're here for your deposition pursuant to notice, and it will be taken pursuant the Federal Rules of Civil Procedure. Do you understand that?

THE WITNESS: I do.

MR. LAND: Have you had your deposition taken before?

THE WITNESS: No.

MR. LAND: Let's go over a few ground rules to keep in mind today. Let me start with how would you prefer me to address you? Is it okay for me to call you by your first name?

THE WITNESS: Yes. Maricel is fine.

MR. LAND: So the purpose of today's discussion or deposition is for me to ask questions and get

Page 5

answers from you. As we do that, I'd like for you to if you can allow me to finish my question before you answer even if you anticipate what I might be saying. Okay?

THE WITNESS: Yes.

MR. LAND: That allows the court reporter to get it down.

The other thing is to try to answer out loud --

THE WITNESS: Okay.

MR. LAND: -- as you've been doing so the court reporter can get it down too.

If you don't understand the question I ask, please let me know that and I can rephrase it. Okay?

THE WITNESS: Okay.

MR. LAND: Otherwise if you answer a question, I'll assume you understood what I meant in asking you. Okay?

THE WITNESS: All right.

MR. LAND: We can take a break any time during today. It's not meant to be a marathon session. So if you would like a break, you can just let me know.

The only thing I'd ask is that if I've asked you a

Page 6

1 question you answer it before we take a break. Okay?

2 THE WITNESS: Of course, yes.

3 MR. LAND: Let me you -- And this is related to
4 understanding your ability to remember things. It's a
5 common question asked. Are you taking any medication
6 that would impede your ability to recall?

7 THE WITNESS: No.

8 (Marcial Deposition Exhibit No. 1
9 was marked for identification.)

10
11
12 MARICEL MARCIAL,

13 Called on behalf of the Defendants, having been first
14 duly sworn, was examined and testified as follows:

15
16
17 DIRECT EXAMINATION

18 BY MR. LAND:

19
20 Q Maricel, let's hand you what's been marked
21 as Exhibit Number 1. Do you recognize this document?

22 A Yes.

23 Q What is it?

24 A It's an amended complaint by my party

Page 7

1 against Rush University Medical Center and the
2 individuals named herein.

3 Q Okay. So this is a copy of your lawsuit
4 setting for your claims in this case; right?

5 A Yes.

6 Q Could you turn to what's marked Page 13.
7 I'll ask you some questions about this, but first the
8 claims you've raised in this case have to do with, in
9 part, discrimination, harassment, and retaliation;
10 right?

11 A Yes.

12 Q And based on national origin, race, and
13 age?

14 A Yes.

15 Q You have some other claims against the
16 individual defendants, and we will talk about those
17 later. But I want to focus on the discrimination
18 claims and harassment claims and those bases.

19 If you look at the top of Page 13 and
20 the paragraphs that are enumerated A through F, there
21 is a list there of categories of conduct I think you
22 are claiming was discriminatory or harassing; is that
23 right.

24 A That's right.

Page 8

1 Q And is this a complete list of the
2 categories of conduct you believe was discriminatory
3 or harassing that you are seeking to pursue in this
4 case?

5 A As far as I can surmise here, yes.
6 I believe this is pretty complete.

7 Q Are you aware as you sit here now of
8 anything else that you claim is discriminatory or
9 harassing?

10 A Not that I can recall right now.

11 Q Okay. So in paragraph A it indicates you
12 were harassed by and given false negative evaluations
13 from supervising CRNAs. Do you see that?

14 A Yes.

15 Q Is part of your claim there that you were
16 both given false negative evaluations but also
17 addressed in ways during your attempts to attend to
18 patients in clinical settings in ways that impacted
19 your ability to perform?

20 A Yes. I believe that.

21 Q So those are two different things?

22 A I believe both happened to me.

23 I experienced both during my time there.

24 Q I don't see anything listed in these

Page 9

1 categories about comments that anyone made to you
2 about your race or your national origin. I'm
3 wondering are you claiming that anyone at Rush during
4 the time that you were enrolled in the SRNA program,
5 did anyone make any derogatory comments to you based
6 on race or national origin?

7 A Not that I recall.

8 Q I'm sorry?

9 A Not that I recall.

10 Q What does that mean?

11 A Well, I didn't hear anything outright that
12 directed their comments towards my race that directed
13 their actions, so no comments that I've heard that's
14 directed to my race or origin.

15 Q Okay. So no comments about your race or
16 national origin?

17 A Yes.

18 Q Directly?

19 A Yes.

20 Q At any time while you were enrolled at
21 Rush?

22 A Yes.

23 Q I know there is an allegation -- and we
24 can go over this -- about comments about your age that

<p style="text-align: right;">Page 10</p> <p>1 you address in your complaint that were raised by Ray</p> <p>2 Narbone.</p> <p>3 A Yes.</p> <p>4 Q Other than Ray Narbone, do you recall</p> <p>5 anyone at Rush saying anything to you in a derogatory</p> <p>6 or negative way about your age?</p> <p>7 A Dr. Kremer enforced that statement by</p> <p>8 Mr. Ray Narbone that your age is a hindrance to my</p> <p>9 progression to the program, so he reenforced his</p> <p>10 statements from what I recall.</p> <p>11 Q When you say he, that Mr. Kremer</p> <p>12 reenforced Mr. Narbone's statements, what do you mean?</p> <p>13 A He said, right, Nurse Marcial, do you</p> <p>14 think -- Let me just try to recollect. When</p> <p>15 Mr. Narbone said your age might affect your</p> <p>16 progression, I believe Dr. Kremer said, Yes, Maricel,</p> <p>17 do consider, maybe consider another program, like to</p> <p>18 switch to another program. I think that's how they</p> <p>19 segued it to the Clinical Nurse Ladder Program.</p> <p>20 So, from my impression, he was</p> <p>21 reenforcing Mr. Narbone's statement of my age being an</p> <p>22 impedance to my progression to the program.</p> <p>23 Q Okay. Did Mr. Kremer say anything</p> <p>24 directly about your age?</p>	<p style="text-align: right;">Page 12</p> <p>1 A Yes.</p> <p>2 Q You wrote I believe -- and we can look at</p> <p>3 this later. You wrote some documents at the time that</p> <p>4 explained what he said to you; right?</p> <p>5 A Yes.</p> <p>6 Q Would you rely more on those documents and</p> <p>7 your recitation of what he said to you than your</p> <p>8 ability to remember here today?</p> <p>9 A Yes. I would rely more on that.</p> <p>10 Q If you could turn to -- Let me back up.</p> <p>11 So I believe you're saying that no CRNA ever said</p> <p>12 anything to you in a derogatory way about your race;</p> <p>13 right?</p> <p>14 A Correct.</p> <p>15 Q And no CRNA at Rush ever said anything</p> <p>16 negative or derogatory to you about your national</p> <p>17 origin?</p> <p>18 A Yes.</p> <p>19 Q And no CRNA ever said anything derogatory</p> <p>20 or negative about your age; right?</p> <p>21 A Yes.</p> <p>22 Q What about Judy Wiley, did she say</p> <p>23 anything degenerative or negative about your age,</p> <p>24 race, or national origin?</p>
<p style="text-align: right;">Page 11</p> <p>1 A No.</p> <p>2 Q And the comment you were describing</p> <p>3 occurring in the same meeting with Mr. Narbone?</p> <p>4 A Yes.</p> <p>5 Q You said something there about Mr. Narbone</p> <p>6 saying that age might affect your progression?</p> <p>7 A Yes.</p> <p>8 Q Did he say those words?</p> <p>9 A No. I can't really say the exact words</p> <p>10 except for what's stated here. I guess I'm</p> <p>11 summarizing it, what he said, that don't you think</p> <p>12 you're too old for this program; and we wrote it down</p> <p>13 here.</p> <p>14 Q So I think you're saying as you sit here</p> <p>15 you don't remember exactly what Mr. Narbone said about</p> <p>16 your age during that meeting?</p> <p>17 A Just whatever we have written here.</p> <p>18 Q So as you sit here now, you don't remember</p> <p>19 that yourself?</p> <p>20 A Not the exact words; but pertaining to my</p> <p>21 age, I do remember him referring to my age as</p> <p>22 something that would be an impedance to my</p> <p>23 progression.</p> <p>24 Q That's how you interpreted what he said?</p>	<p style="text-align: right;">Page 13</p> <p>1 A No.</p> <p>2 Q If you could turn to Page 19 of your</p> <p>3 Second Amended Complaint, I want to ask you about a</p> <p>4 couple of questions. Near the bottom of the page it</p> <p>5 lists Count 4, retaliation and violation of Title VII</p> <p>6 and then a series of other words. Do you see that?</p> <p>7 A Uh-huh.</p> <p>8 Q I'm sorry?</p> <p>9 A Yes.</p> <p>10 Q So in Paragraph 86 it indicates that you</p> <p>11 submitted a complaint of discriminatory abuse and</p> <p>12 mistreatment to the director of the Compliance Office,</p> <p>13 Shannon Shumpert. Do you see that?</p> <p>14 A Yes.</p> <p>15 Q It indicates that was submitted in April</p> <p>16 of 2014?</p> <p>17 A Yes.</p> <p>18 Q Is that right?</p> <p>19 A Yes. That's correct.</p> <p>20 Q Had you raised any complaint about</p> <p>21 discrimination or harassment on the basis of your age,</p> <p>22 race, or national origin before 2014?</p> <p>23 A No.</p> <p>24 Q So the first time you raised those</p>

Page 14

1 concerns about discrimination were in April of 2014;
2 is that right?

3 A I had in my meetings with Dr. Kremer had
4 verbally complained to him that I feel there was some
5 discriminatory or disparate treatment that I was
6 receiving, so with Dr. Kremer I have.

7 Q When did you first do that?

8 A To the best of my recollection, it was
9 right after I received about three false negative or
10 negative evaluations in my performance. I raised the
11 concern that I felt like I was being discriminated on.

12 Q When was that?

13 A On or about about my leave of absence,
14 probably a couple weeks before that.

15 Q Are you sure? You're talking about your
16 leave of absence in 2013?

17 A 2013.

18 Q Are you sure that you told Mr. Kremer
19 about your leave of absence that you thought your
20 mistreatment was discriminatory on the basis of your
21 national origin, race, or age?

22 A I believe I had mentioned to him that I
23 felt that owing to my interaction with my other
24 minority classmates, particularly Karen Kam, also a

Page 15

1 Filipino who had received some -- She went through
2 some harassment with Jill Wimberly as well. With that
3 in mind, I presented my complaint to Dr. Kremer.

4 Q I'm trying to understand how certain you
5 are that in your communication with Dr. Kremer that
6 you mentioned age, race, or national origin
7 discrimination in 2013? How certain are you that you
8 did that then?

9 A I'm certain about the race, but I didn't
10 raise the issue with age and national origin just
11 because with Karen she was also paired with another
12 white student; and Jill mistreated her but not the
13 other white student who was Kim Huntzinger.

14 So Karen had disclosed to me that she
15 felt there was discriminatory treatment between the
16 two of them because Miss Wimberly left Kim Huntzinger
17 alone while grilling Karen tremendously; and I felt
18 the same way. So Karen had warned me the night before
19 of Miss Wimberly's actions.

20 Q You are saying it was sometime after Karen
21 Cam told you that that you told Dr. Kremer you
22 believed you were subjected to discriminatory
23 treatment?

24 MS. SIEGEL: I'm going to object. I believe

Page 16

1 you misspoke. You might want to ask the question
2 again.

3 MR. LAND: Q Did you understand what I said?

4 A No.

5 Q You're talking about a conversation with
6 Karen Kam?

7 A Yes.

8 Q You believe it was after a conversation
9 with Karen Kam that you reported to Dr. Kremer that
10 you were subjected to discriminatory treatment on the
11 basis of your race; is that right?

12 A Not immediately after. It was over a
13 couple of -- well, after I received a couple of
14 negative evaluations in the course of our -- I think
15 we had three meetings I had raised that concern.

16 Q Three meetings with Dr. Kremer?

17 A Dr. Kremer and with Dr. Wiley.

18 Q During the summer of 2013?

19 A Yes.

20 Q Are you sure that it was one of those
21 three meetings that you raised the discrimination
22 issue with Dr. Kremer?

23 MS. SIEGEL: It's been asked and answered.
24 You may answer.

Page 17

1 A I believe it was in one of those meetings
2 that I raised that concern.

3 MR. LAND: Q The reason I ask is because you
4 say you believe and not that you know.

5 A Yes.

6 Q And I'm not sure if you do know.

7 A I'm not sure which part of the or which of
8 the meetings, but I know in one of the meetings I had
9 raised that concern.

10 Q Only one of them?

11 A I believe so because from what I recall,
12 Dr. Kremer countered or argued with me that, Are you
13 alleging that they're colluding against you, and I
14 vehemently responded, Yes, I believe they are
15 colluding against me.

16 Q Are you saying you had that discussion in
17 the same meeting where you reported you believed it
18 was because of race discrimination?

19 A It might have been leading up to another
20 meeting, but I'm not sure of which part of it; but I
21 know that I had raised that concern in probably a
22 later meeting that we had prior to my leave of
23 absence.

24 Q Who was in the meeting when you raised the

Page 18

1 issue of race discrimination with Dr. Kremer?

2 A Just Dr. Kremer.

3 Q Let me ask you a little bit about your
4 background. So before you enrolled in the SRNA
5 program at Rush you were an ICU nurse?

6 A Yes.

7 Q How long were you in that role?

8 A About 13 years prior to my start because I
9 started as an ICU nurse in 2000, so I think I
10 matriculated around 2012. So when I started the core
11 program, it was 2013. So about 13 years of ICU
12 experience.

13 Q What does an ICU nurse do generally?

14 A So I'm a primary bedside nurse. I usually
15 have about two to three patients that I provide
16 critical care to them primarily for patients who have
17 medical and cardiac critical conditions.

18 I also collaborate with the doctors in
19 bringing to them like the status of the patients and
20 the treatment plans.

21 I've also participated in the
22 committees in our unit, primarily in informatics and
23 also some safety measures that we enforce in the unit.

24 I've also done some teaching of like

Page 19

1 new orientees and nursing students who visit our unit.

2 Q Do you interact with anesthesiologists as
3 an ICU nurse?

4 A On occasions when I have to bring my
5 patients to surgery or if they come and would like to
6 ask about the status of the patient, when the
7 anesthesiologist would come up to our unit to ask
8 about patient's condition and any special background,
9 medical conditions that would preclude them from
10 surgery.

11 Q So before or after surgery you might
12 consult with an anesthesiologist?

13 A Before surgery and afterwards too, where
14 they give me a report of what kind of anesthetic
15 management they did and any events during surgery and
16 also preferences and pain management postoperatively.

17 Q So as an ICU nurse, you did not consult or
18 talk with any anesthesiologist during surgery?

19 A On occasions I would call them and report
20 to them about possible special needs the patient may
21 have that would enable or optimize the patient for
22 surgery. Like if they have a history of postop nausea
23 and vomiting, then I try to highlight that to make
24 sure that they premedicate the patient enough that

Page 20

1 this complication doesn't occur afterwards.

2 Q You would have that conversation during
3 surgery?

4 A No, no before surgery.

5 Q My question was have you ever interacted
6 with anesthesiologists during surgery?

7 A No.

8 Q Do you ever interact with
9 anesthesiologists during surgery?

10 A No.

11 Q You talked about collaborating with
12 doctors about treatment plans?

13 A Uh-huh.

14 Q Would the doctors direct you to what to do
15 with the treatment plan as an ICU nurse?

16 A On occasion I would present some
17 treatments or needs that the patient might have and
18 request for them to order certain procedures or
19 certain treatments like physical therapy or wound
20 care.

21 Also I would report, you know, current
22 status, highlight the abnormalities or significant
23 symptoms that a patient might have and the progress of
24 their care, so mostly reporting status, requesting for

Page 21

1 orders for the patient's progression. And that's
2 mostly the gist of it, the interactions with them.

3 Q So the doctors would decide on treatment
4 plans and might take your input --

5 A Yes.

6 Q -- into their consideration in making
7 those decisions?

8 A Yes.

9 Q But you wouldn't decide on the treatment
10 plan as the ICU nurse; right?

11 A No.

12 Q How much independent judgment did you have
13 as an ICU nurse about treatment of patients?

14 A I would say some amount of independent
15 judgment because on occasions we would -- Like let's
16 say a patient's blood pressure is dropping. Then I
17 would go ahead and start fluids before I can reach the
18 doctor because I know that that's our protocol.

19 There are also some pre-made or like
20 nurse-driven orders that, like a sepsis protocol,
21 where we draw labs and follow the guidelines of what
22 to do in managing a patient who is in septic shock.

23 Q Would you would it's fair that most of
24 your treatment of patients as an ICU nurse, most of

Page 22

1 your treatment was directed by doctors or physicians?

2 A Yes.

3 Q Let's talk a little bit about the SRNA
4 program. So what would you say the objectives and
5 requirements are for the SRNA program? What's the
6 goal of enrolling in that program?

7 A The goal is to be able to provide
8 efficient and safe service in anesthesia, to be able
9 to act independently as a professional nurse
10 anesthesiologist, to be able to work with a team
11 effectively and I guess enforce the care or the
12 provision of care provided by the anesthesia staff.

13 Q The degree of acting independently as a
14 CRNA, is that different than an ICU nurse?

15 A I would say there is much more autonomy as
16 a CRNA.

17 Q Would you agree that working as a CRNA
18 involves conduct that can relate to the life and death
19 of the patients?

20 A Yes.

21 Q More so than an ICU nurse?

22 A I feel -- From my experience, I engaged in
23 more death situations like Code Blue or cardiac
24 arrests. So I forgot to mention that earlier, that I

Page 23

1 was part of the Code Blue team, so that's about a two
2 to three times a week basis when I'm at work. So I
3 run to emergency events where I participate in
4 reviving or resuscitating patients.

5 So I've seen that happen more in my
6 time as an ICU nurse than in my time as a Student
7 Registered Nurse Anesthetist or as an SRNA.

8 Q So aside from a comparison to your ICU
9 experience, would you agree that CRNAs would be in
10 positions to affect life and death consequences for
11 patients in administering anesthesia?

12 A Yes.

13 Q And that's an important element of patient
14 safety for CRNAs?

15 A Yes.

16 Q Are the standards of the Rush SRNA program
17 high? Are they difficult and tough?

18 A From our perception -- it was students --
19 yes, we felt they have standards that we have to
20 maintain; and some are difficult but not
21 insurmountable.

22 Q Do you think there is a correlation
23 between how difficult those standards are and how
24 important they are to how important the life and death

Page 24

1 approach to anesthesia is?

2 A To some extent I do although in
3 researching other programs I felt that their standards
4 correlated with the quality of care that they provided
5 without compromising the safety and health and
6 well-being of their student residents.

7 Q I'm not sure what you're referring to
8 there. Are you saying other programs when you say
9 they?

10 A Uh-huh, other programs.

11 Q So the SRNA program had kind of two main
12 components, right, a didactic component and a clinical
13 component?

14 A Yes.

15 Q How long was didactic component?

16 A Well, I had to same take some
17 prerequisites. So from what I recall, I think it took
18 me two years for the prereqs, and then the core
19 competencies I would approximate around two years.

20 Q So you started in --

21 A 2011 I was already taking courses,
22 prerequisites like anatomy and statistics.

23 Q When did you finish with your courses, the
24 didactic part?

Page 25

1 A I believe May of 2013.

2 Q Did any aspect of the didactic part of the
3 program at Rush involve clinical work?

4 A During the didactic courses, we had about
5 two days of the week that we were in clinicals.

6 Q Who oversaw your work when you were in the
7 didactic part of the program but in the two or
8 three days a week of clinicals?

9 A I'm sorry?

10 Q What role of the person oversaw your work
11 or evaluated you?

12 A So CRNAs and Dr. Kremer providing the
13 lectures and Dr. Wiley as well.

14 Q Did Mr. Narbone ever evaluate your work in
15 the clinicals during the didactic program?

16 A No.

17 Q Did you believe that the evaluations of
18 you during that component of the program were fair?

19 A Well, the didactics were graded, so I felt
20 they were fair; and in the clinicals, yes, I believe
21 most of them were. I believe they're fair.

22 Q Did you ever tell anyone at Rush that you
23 thought any component of the clinical evaluation of
24 you during the didactic portion of the program was

Page 26

Page 28

1 unfair?

2 A Not that I recall.

3 Q Does that mean you didn't or you are not

4 sure?

5 A I think with my classmates we compared,

6 I guess we compared our evaluations at times and had

7 our own like opinions of how they were graded as

8 compared to our other classmates.

9 Q Do you believe as you sit here now that

10 any evaluation of you by a CRNA during the didactic

11 part of the program in the clinicals was unfair?

12 A I don't think so, that there was --

13 I thought they were fair then.

14 Q Do you think they're fair now?

15 A Not for the later clinical evaluations

16 during my -- Oh, you mean if --

17 Q I'm talking about the earlier ones.

18 A Right now?

19 Q Yeah.

20 A Yes. I think they are fair.

21 Q During the didactic part of the program,

22 was part of that involving learning certain drugs?

23 A Yes.

24 Q How they worked?

1 were on that list?

2 A We have Atropine, neostigmine,

3 glycopyrrolate. There is phenylephrine, pain

4 medications of course, morphine, fentanyl.

5 Q How about muscle relaxants?

6 A Yeah, muscle relaxants, reversal drugs,

7 induction medications like Versed and some anesthetics

8 like Lidocaine.

9 Q What muscle relaxants do you remember

10 being on the list?

11 A I believe they're rocuronium,

12 succinylcholine, cisatracurium.

13 Q And which reversal drugs were on the list

14 that you needed to know by heart?

15 A Gosh, there is like glyco and neostigmine

16 and -- I don't recall right now. I haven't seen those

17 things in a while.

18 Q That was impressive. I know it's been a

19 while.

20 So you didn't just need to learn the

21 name of the drug. You needed to learn what it did?

22 A Yes.

23 Q And what else would you need to learn

24 about those drugs?

Page 27

Page 29

1 A Yes.

2 Q Dosages?

3 A Yes.

4 Q I know I'm speaking very generally here

5 about what I assume is a very significant part of the

6 program; is that right?

7 A Yes.

8 Q Was there a list of drugs that you needed

9 to know about by heart and dosages and their actions,

10 how they worked in the body?

11 A Mostly the emergency drugs. We had sort

12 of a rough guide of which ones we have to know by

13 heart.

14 Q When you say it was a rough guide, what do

15 you mean?

16 A Well, I guess each student -- Well, we

17 were given the basic emergency drugs and what we need

18 to be more familiar with; and each student also added

19 to their list of things to know by heart during, you

20 know, the didactics.

21 Q As part of the Rush program, were you

22 given a list of drugs to know by heart?

23 A Yes.

24 Q What do you remember were the drugs that

1 A Any contraindications, any particular

2 patient medical history that would be considered in

3 choosing which kind of drug would be appropriate for

4 them.

5 Q What about knowing the drug's actions?

6 A Yes.

7 Q What does that mean, a drug's actions?

8 A The physiology or how it affects the

9 body's physiology and the duration or the onset of

10 start, like what effect it actually provides and

11 duration of actions, mechanism of action of the drug.

12 Q So for each of the drugs on the list you

13 need to know what it was. You need to know how it

14 worked in the body and how long it would affect the

15 patient?

16 A Yes.

17 Q What about dosages?

18 A Yes, that too.

19 Q Is there a range of appropriate dosage?

20 A Yes.

21 Q For different drugs?

22 A Yes. Some of the drugs were weight-based;

23 and depending on also the medical comorbidities of the

24 patient, then you taper or tailor it to that patient's

Page 30

1 unique needs.

2 Q And that was again part didactic program;
3 right?

4 A Yes.

5 Q So by the time you moved into the later
6 part of the program was which was the clinical part --

7 A Yes.

8 Q -- say, I don't know, sometimes you refer
9 it to the residency, you were expected to know all of
10 those drugs by heart and how they worked and their
11 actions and duration; right?

12 A Yes. That's fair. That's why we carry
13 our what they call cheat sheet or little cards to
14 remind us because there are quite a bit of them; and
15 the range of doses can be confusing for some students,
16 for us.

17 Q What does it mean to know a list of drugs
18 and how they work by heart? I think it means you
19 don't need to refer to something. But does that mean
20 something else to you?

21 A Yes. Even if you know it by heart, for me
22 and most of my classmates, we still refer to a card to
23 make sure that we are appropriately dosing the patient
24 because there are some drugs that have very close dose

Page 31

1 ranges.

2 And to be sure that we're not making
3 any mistakes, we're referring to those guides off and
4 to make sure that we have the correct dosages. Even
5 though I mean we are familiar with the drug, the
6 numbers are still what throws us off sometimes, and so
7 we have to refer to our dosage references.

8 Q So let's talk about the clinical part of
9 the program. Is it okay if we call that the residency
10 part?

11 A Okay.

12 Q For you that started in May of 2013; is
13 that right?

14 A Yes, like a later part of May.

15 Q And the clinical component, the residency
16 part of the program is different than the didactic
17 part; right?

18 A Yes.

19 Q How is it different?

20 A Well, we were in the clinical area five
21 days a week, sometimes six to do postoperative
22 follow-up. We would probably be in class for journal
23 club they call it where we discuss some articles, and
24 there is also some classwork where we presented our

Page 32

1 assigned I guess topics that relate to anesthesia.

2 Like I think in my case I presented
3 patient-controlled analgesia in one of the -- I forgot
4 what they called it, capstone -- it's not capstone but
5 one of those student presentations. So there is
6 limited class work but mostly clinical work.

7 Q When you say mostly clinical work, like
8 what percentage of your time was spent in clinicals?

9 A I would say about 90 percent.

10 Q Were the requirements, expectations for
11 you during residency different than they were during
12 the didactic part of the program?

13 A I believe they were because that's more,
14 you know, hands on like clinical exposure, yeah.

15 Q Were the expectations of your ability to
16 apply what you learned to the clinical setting higher
17 during the residency program?

18 A Yes.

19 Q So you were expected to be able to apply
20 knowledge you had learned in the didactic part of the
21 program; right?

22 A Yes.

23 Q When you were in the clinicals during
24 residency, was it common for the anesthesia plan you

Page 33

1 had set for a particular case to change?

2 A Yes. Well, it's not uncommon, but you
3 expect it to happen.

4 Q Did you say it's not uncommon?

5 A It's not very --

6 Q Let me back up.

7 A Yeah.

8 Q Is it common for the anesthesia plan to
9 change during a case? Did you experience that when
10 you were in the residency program?

11 A Not a whole lot. It usually was it pretty
12 consistent.

13 Q What do you mean by that?

14 A So if we prepared for -- because prior to
15 our cases in the morning, we look up the patients,
16 their history, and we devise an anesthesia care plan
17 that basically has the drugs that we plan to use the
18 next day.

19 But of course if there is an emergent
20 issue that arises during surgery, then that's where
21 plans may not follow the care plan that we have
22 prepared the night before.

23 Q Are you saying that in your experience
24 most of the time the care plan you prepared the night

Page 34

1 before is just what you followed during the case?

2 A For the most part.

3 Q How often would you have to vary from
4 that?

5 A That's usually just a guide; so in
6 different cases, different things arise and of in the
7 course of the surgery. So I don't know that there is
8 much that --

9 I can't really recall like a particular
10 case; but for the most part we followed the guide, and
11 it just gives us sort of an overview of what to expect
12 during surgery.

13 Q When you say guide, I think you're also
14 referring to the anesthesia plan that you prepared the
15 night before?

16 A Yes.

17 Q Did it have options to consider during the
18 case?

19 A I think on like one of the pages we --
20 Because we have to tailor it to the patient's
21 comorbidities or other conditions, then we have --
22 Well, I prepare like in one of the pages how this
23 disease would -- We anticipate or I would anticipate
24 certain things that could happen as a result of the

Page 35

1 patient's comorbidity, so I add that towards the end
2 of my care plan as I anticipate the possibility of
3 these complications.

4 Q Okay. That's what I'm trying to get at.
5 Aside from specific examples like that, isn't it
6 common in the course of the case that you would need
7 to make some decisions about what to do from an
8 anesthesia care perspective?

9 A Yes.

10 Q So you would need to understand your guide
11 or your plan but adjust to the circumstances?

12 A Exactly.

13 Q And was that every time you'd have to do
14 that or was it part of the time?

15 A Well, there are some cases that are more
16 simple, so things go along as planned. I would say
17 most of the time it goes the way we planned it.

18 Q By that you mean you wouldn't have to make
19 any decisions during the case about treatment or do
20 you mean something else?

21 A No. There are tweaks that happen
22 throughout with each surgery. So I guess what I'm
23 saying is the guide, I mean the plan is just your
24 overview guide; but you come in expecting that things

Page 36

1 can change dramatically from one minute to the next.
2 So you would anticipate how to treat or possibly see
3 what you can do to treat those occurrences.

4 Q Would you say it's accurate to say there
5 are dozens of decision points you have to make during
6 a particular case as an SRNA?

7 A Yes.

8 Q On each patient there would be dozens of
9 them?

10 A Yes.

11 Q As part of the residency program were you
12 required to show the ability to exercise your judgment
13 when conditions changed in the course of a case?

14 A Yes.

15 Q And that's pretty much every patient?

16 A Yes.

17 Q And that was different than the didactic
18 part of the program?

19 A In terms of the clinical part in the
20 didactic?

21 Q Yeah, the judgment element, the
22 requirement or you as an SRNA to demonstrate your
23 judgment in the moment of a case, was there a
24 heightened element to exercise that judgment during

Page 37

1 the residency program?

2 A Yes.

3 Q Was part of your role in the residency
4 program that you needed to be able to react to
5 information as it evolved during the course of a case?

6 A Yes.

7 Q Would that include recognizing and
8 diagnosing issues and making decisions about keeping
9 patients safe?

10 A Yes.

11 Q Would you say it's accurate to say that
12 CRNAs exercise judgment about what to do during the
13 course of a case about 80 to 85 percent of the time?

14 A CRNAs in collaboration with the
15 anesthesiologist sometimes even at the start of a case
16 I've seen where a CRNA would present an anesthesia
17 plan and an anesthesiologist will also kind of modify
18 it; and so it's like an agreement between the two.

19 Q How much of the time do you think a CRNA
20 makes a completely independent judgment during the
21 course of a case?

22 A I would say about 80 percent.

23 Q And that is a big change from being an ICU
24 nurse; right?

Page 38

Page 40

1 A Yes.

2 Q During your first term of residency, you
3 were initially assigned with a CRNA to every case?

4 A Yes.

5 Q Sort of one-on-one monitoring of your work
6 as a SRNA?

7 A Yes.

8 Q Did you ever progress past that?

9 A I had occasions prior to -- well, in the
10 summer I think around June when I was with Dr. Wiley a
11 couple of times where I was left alone in some of the
12 cases because she was also overseeing another student.
13 So for the majority of the case I was by myself.

14 And then in other cases too
15 sporadically throughout the residency I had periods
16 where I'm alone in the room because there was only one
17 lead shield they call it where there is a constant use
18 of fluoroscopy or X-ray technology that only affords
19 protection -- the lead shield only affords for one
20 staff.

21 So my CRNA and anesthesiologist would
22 sometimes be in the monitoring room adjacent to the OR
23 suite, and basically I would be running the provision
24 of anesthesia with hardly any feedback from them.

Page 39

1 Q But they were there?

2 A They were in the monitoring room just
3 looking, but for the most part I managed the majority
4 of the case.

5 Q But they were watching what you were
6 doing?

7 A Yes.

8 Q Would you say that the vast majority of
9 time during your residency program you were supervised
10 by a CRNA?

11 A Yes.

12 Q And as part of the program within the SRNA
13 program and the clinical development part to start
14 weaning SRNAs from one-on-one supervision?

15 A Yes.

16 Q And you never entered that phase; right?

17 A I was not allowed to enter into that
18 phase.

19 Q Why weren't you allowed to enter into that
20 phase?

21 MS. SIEGEL: I'm going to object. That calls
22 for speculation.

23 MR. LAND: Q You can answer if you know.

24 A That's their decision. I don't know what

1 their decision paths were to make that, to put me into
2 one-to-one supervision the whole time.

3 Q No one ever told you why they wouldn't put
4 you into one-to-one, take you away from the one-to-one
5 supervision component?

6 A Dr. Wiley had mentioned that I still need
7 one-to-one supervision based on supposedly my negative
8 evals, although one of the clinical associate
9 directors, Renee Prygodzka had told me or asked me,
10 Why are you still not on your own? You are more than
11 ready. So I have had experiences with her several
12 times, and she had seen my work.

13 Two other anesthesiologists had
14 mentioned that observation.

15 Q Two other anesthesiologists is?

16 A Yes. One was Dr. Lai, and I believe the
17 other one was Dr. Katsionis (phonetic).

18 Q Can you say Renee's last name again?

19 A It's Prygodzka, P-r-y-g-o-d-z-k-a.
20 I think that's how you spell it.

21 Q When did she tell you she thought you
22 could be on your own?

23 A This was when I came back from my leave of
24 absence.

Page 41

1 Q So in 2014?

2 A Yes.

3 Q Do you know when in 2014 she said that to
4 you?

5 A So we had done -- I'm trying to think. It
6 was after one of our breaks in the endoscopy unit, and
7 so I would say probably around February. She had
8 filled out an eval, so I would be able to know more of
9 the dates that I was with her.

10 Q During the residency portion of the
11 program, you are aware that the program called for
12 frequent clinical evaluations from CRNAs; right?

13 A Yes.

14 Q And a summative evaluation every term?

15 A Yes.

16 Q Summing up those evaluations throughout
17 the term?

18 A Yes.

19 Q That was the point.

20 Was there a requirement to receive 28
21 written evaluations every term for all you students in
22 the program?

23 A Yes.

24 Q And you knew that when you started the

Page 42

Page 44

1 residency program?

2 A Yes.

3 Q Were clinical courses graded as pass-fail?

4 A Yes.

5 Q Do you know that students were required to
6 consistently meet or exceed standards in order to
7 pass?

8 A Yes.

9 Q And do you know that multiple
10 unsatisfactory ratings or repeated patient safety
11 concerns could be grounds for course failure in the
12 residency program?

13 A I was told that.

14 Q So you knew that when you started?

15 A Yes.

16 Q Meaning that if you had an unsatisfactory
17 rating from a CRNA on a clinical evaluation, that was
18 significant to you; right?

19 A Yes.

20 Q It rendered you at risk for failing the
21 course; right?

22 A Yes.

23 Q And it rendered you at risk for failing
24 out of the program?

1 absence.

2 Q Were both of his visits after the leave of
3 absence?

4 A Yes.

5 Q Judy Wiley evaluated you too; right?

6 A Yes.

7 Q Is she a CRNA?

8 A Yes.

9 Q Did Ray Narbone evaluate at all when you
10 were in the residency program?

11 A No.

12 Q Let's talk a little bit about
13 anesthesiologists and their reviews. Were they ever
14 critical of you?

15 A Some would be; but in terms of the written
16 one, they're mostly favorable.

17 Q Were any of them unsatisfactory?

18 A Not that I recall.

19 Q The written ones?

20 A No.

21 Q Do you know if that's common for other
22 students, to have anesthesiologists not provide any
23 written unsatisfactory rankings?

24 A I don't know what my other classmates have

Page 43

Page 45

1 A Yes.

2 Q So it was a big concern to you I assume --
3 but tell me if I'm wrong -- if you received multiple
4 unsatisfactory ratings and clinical evaluations;
5 right?

6 A It was a big concern for me.

7 Q During the clinical component, during the
8 residency program, who evaluated you?

9 A There were multiple CRNAs.

10 Q CRNAs evaluated you?

11 A Anesthesiologists. Those are the two main
12 people. And Dr. Kremer had come in a couple of times
13 to look at my work. So in some sense he gave me
14 feedback. He had emailed me about, when he came to
15 visit me one time.

16 Q One time?

17 A Well, he visited me twice, but he emailed
18 me this one time to remind me, also to him -- I think
19 it was Jim Miller I was with at that time -- an
20 evaluation; and he also gave me feedback on how I did.

21 Q Do you remember when Dr. Kremer reviewed
22 you that way or evaluated you if it was before your
23 leave of absence or after?

24 A I believe it was after my leave of

1 gotten. We don't really share or show each other's
2 evaluations for the most part, so I don't know what
3 theirs looks like.

4 Q Did you ever hear of any other student
5 getting an unsatisfactory ranking from an
6 anesthesiologist?

7 A I've heard one or two.

8 Q Did you ever hear that anesthesiologists
9 are pretty much easier graders than the CRNAs?

10 A I think I heard that from my one
11 classmate.

12 Q Okay. Do you know if that's true?

13 A I guess it all depends on which
14 anesthesiologist you're approaching and also how the
15 case went. Even if it was a nicer anesthesiologist,
16 if he really felt that you were not performing well,
17 then you get what you deserve. I felt they were fair
18 enough and not overly -- gracious with grading.

19 Q Were the CRNAs the primary people
20 responsible for evaluating grading SRNA's program
21 performance?

22 A At the beginning, but later on the
23 anesthesiologists also took a much more frequent role
24 in grading the SRNAs.

Page 46

Page 48

Q In your experience did that happen?

A That's usually what we experience.

Q You're talking about what you experienced is my question.

A What is the question?

Q You were saying as you moved on in the program, anesthesiologists provided more evaluation?

A Yes.

Q And that happened to you?

A No, because I was mostly one to one with a CRNA. So if either the CRNA has left and the anesthesiologist is there still there, then I would give the evaluation to them.

Q So when you talk about anesthesiologists providing more evaluative information, that's at the point of the program when SRNAs moved beyond the one-on-one monitoring with the CRNA?

A Yes.

Q You were saying Ray Narbone did not do any evaluating of CRNA performance in the residency program; right?

A Of my performance, yeah.

Q What's your understanding of what his role was with respect to the SRNA program?

to get a certain number of those cases in your requirement.

Q Do you have a sense there is an attempt in scheduling SRNAs the cases to get them a variety of exposure to different kinds of cases?

A I guess so.

Q And different medical situations?

A Yes.

Q Do you know if there is any -- You may not, but is there any effort to consider how complicated a situation might be based on how an SRNA is performing, whether they can handle it?

A I think there is some consideration to that, but I really don't know what his algorithm is to assign.

Q Do you know if there is any effort to mix up who SRNAs are paired with respect with respect to CRNAs?

A There is some, yes. I think there is -- You know, they try to attempt that.

Q Is there any goal to get SRNAs used to working with different people because that's part of what CRNAs actually do?

MS. SIEGEL: Object: Calls for speculation.

Page 47

Page 49

A I think he -- Well, the job that I know he does is he coordinates the cases by assigning them to particular anesthesia staff. So he I guess runs interference or what do call it, scheduling cases with anesthesia staff and also scheduling, you know, SRNAs, their case loads for the day.

Q Do you know anything else about any role he played within the SRNA program?

A As far as I know, he's the chief of the CRNAs; so he coordinates with them or talks to them about their affairs or whatever agenda they have. I'm not really sure what his direct role is with them.

Q What do you mean by any agenda they have?

A Like meetings and student feedback, yeah. That's as far as I know.

Q What do you know about how CRNAs and SRNAs are paired or assigned to cases? I'm not sure if you know much with that.

A No. They don't tell us really how we are paired to certain CRNAs.

I guess -- Well, later on you have to meet a certain case requirement for particular specialties like ENT or neuro; and so I guess it has to be attuned to what specialty you are in to be able

A I don't know.

MR. LAND: Q You don't know?

A No.

Q No one ever talked to you but any goal like that for the SRNA program?

A Not to my recollection.

Q Do CRNAs work with a lot of different people in the OR?

A Yeah. They work with various people that I know.

Q Do you think it's important for CRNAs to get used to working with different people, sometimes people they don't know?

A I think so.

Q It's part of the professionalism of a CRNA?

A Yeah.

Q How many people would be present typically when you were working in the residency part of your program in a particular case? How many people would be there in the operating room with you generally?

A Probably ten, or, no, probably less than that. Depending on the case, it could be as little as four people and as much as maybe ten.

Page 50

Page 52

1 Q That could include another SRNA?
 2 A That's on occasion, but we're talking
 3 about OR staff as well, right, in the room.
 4 Q Uh-huh.
 5 A Yeah.
 6 Q I'm wondering about people who would be
 7 present when you would have been engaged in the
 8 residency program in a case in a clinical, would there
 9 be another SRNA there sometimes?
 10 A On occasions, yeah.
 11 Q What about a CRNA, there would always be
 12 one there pretty much; right?
 13 A Yes.
 14 Q And a nurse?
 15 A OR nurse?
 16 Q Yeah.
 17 A Yes.
 18 Q What about a scrub nurse or scrub tech?
 19 A Yes.
 20 Q Maybe a resident?
 21 A Usually residents -- well, surgical
 22 residents of course.
 23 Q And maybe an anesthesiologist resident
 24 too?

1 Q Is that the ventilator?
 2 A The anesthesia machine they call it, but
 3 it is a ventilator.
 4 Q Is it a common setup to have airway
 5 management steps ready?
 6 A Yes.
 7 Q And does that include having a breathing
 8 tube, having a correct size and other instruments?
 9 A Yes.
 10 Q Is it a common step to have suction set
 11 up?
 12 A Yes.
 13 Q And that involves connecting to the vacuum
 14 system that exists in the building?
 15 A Yes.
 16 Q And hook it up from the wall to a canister
 17 and then to the patient; is that right?
 18 A Well, from the wall to the canister; and
 19 then it's just an open vacuum area that you use to
 20 attach to like what they call a suction device, a
 21 Yankauer. So it's not attached to the patient. It's
 22 just used as needed to clean out the patient's
 23 secretions or any, you know, blood that might be on
 24 the patient, to help clean them up.

Page 51

Page 53

1 A Usually they don't perform in the same
 2 case. They have their own assignments if they're
 3 anesthesia residents.
 4 Q Okay. And there would always be an
 5 anesthesiologist there when you were engaged in
 6 clinicals during the residency program; right?
 7 A Yes.
 8 Q Would those people generally be able to
 9 observe what you experienced when you are in a case?
 10 A I don't know if they would be paying
 11 attention to me so much as the whole case itself.
 12 Q But they're present and could observe?
 13 A Yes.
 14 Q You are not sure if they would, but they
 15 could; right?
 16 A Yes. They could.
 17 Q Let me ask you about some basic
 18 anesthesiology setup common steps; and I'm obviously
 19 not an anesthesiologist or trained, so forgive me if I
 20 explain things, correct me if I explain it
 21 incorrectly.
 22 Is it a common step to check the
 23 anesthesia machine?
 24 A Yes.

1 Q Thank you. I understand that.
 2 Did you learn about suction and how
 3 that worked when you were an ICU nurse?
 4 A Yes.
 5 Q So you were fairly familiar with the wall
 6 to the canister and then use on the patient, that
 7 process?
 8 A Yes.
 9 Q Is another common setup step to have the
 10 appropriate drugs drawn up and labeled?
 11 A Yes.
 12 Q And what does it mean to have a drug drawn
 13 up?
 14 A So you have it in a syringe and make sure
 15 you have the right drug label on it. On occasion like
 16 different people have labeled it differently where
 17 like with residents, they don't even bother to write
 18 the dosages there. But for us, we mostly write our
 19 doses there. But if it's the right label, then you
 20 know that you have the right drug that you are giving
 21 to the patient.
 22 Q So when you say residents might not do
 23 that, what kind of residents?
 24 A Medical residents or sometimes --

Page 54

1 Q So CRNAs write both the name of the drug
2 and the dosage?
3 A Yes.
4 Q On the syringe?
5 A Yes.
6 Q On a label put on the syringe?
7 A Yes.
8 Q And that was the expectation for you too?
9 A Yes.
10 Q Would you say that the core of your claims
11 have of discrimination is that CRNAs fabricated and
12 falsified clinical evaluations of your performance?
13 A I believe some of the false evaluations
14 weren't entirely, misrepresented my work.
15 Q Did some of them accurately represent your
16 work?
17 A No.
18 Q None of them did?
19 A I mean some of them did not accurately
20 represent my work.
21 Q Did some of the critical evaluations of
22 your work accurately reflect your work?
23 A Yes.
24 MS. SIEGEL: Are you going into a new set of

Page 56

1 A Yes.
2 Q I just want to direct your attention to a
3 few of these pages. Like the first page, it appears
4 to be a review of you by Judy Wiley from April 11,
5 2013; is that right?
6 A Yes.
7 Q Is her review of you here positive?
8 A It says here satisfactory.
9 Q And do you think that this review was fair
10 of you?
11 A I believe I performed well that day.
12 Q Do you think this review is fair?
13 A Yes.
14 Q It indicates in the comments: Overall a
15 good day, need to work on putting things together and
16 application what you've learned; right?
17 A Yes.
18 Q Is that a fair comment?
19 A Yes.
20 Q The next page is an evaluation from March
21 28th, 2013, the date of your case in the clinical
22 residency program, right, by Mary Rodzik; is that
23 right?
24 A Yes.

Page 55

1 exhibits?
2 MR. LAND: Yeah. Do you want to take a break?
3 MS. SIEGEL: Yeah.
4 (Whereupon a brief recess was had,
5 after which the deposition of
6 Ms. Marcial continued as
7 follows:)
8 (Marcial Deposition Exhibit No. 2
9 was marked for identification.)
10 MR. LAND: Back on the record.
11 Q I hand you what's marked Marcial
12 Deposition Exhibit Number 2. It's a group exhibit.
13 I don't need you to look at every page in here. It's
14 a compilation of various clinical evaluation forms for
15 you.
16 A Yes.
17 Q These are for the time period preceding
18 your move into the residency program, so really from
19 April, 2013 back through the time in 2012.
20 And you would agree with me that time
21 period is sort of going backwards?
22 A Yes.
23 Q So April of 2013 back into 2012, that
24 preceded your time in the residency program; right?

Page 57

1 Q Was this review positive? It rated you as
2 satisfactory?
3 A It looks -- Overall it says in there
4 satisfactory as well as the comments are positive.
5 Q Did you think this review is fair?
6 A Yeah.
7 Q The next page, it's a review from Alida
8 Hooker from it looks like March 22nd, 2012; but the
9 date it's signed is March 21, 2013. Is that your
10 signature at the bottom as well?
11 A Yes.
12 Q Dated March 21, 2013?
13 A Yes.
14 Q Is this review positive of your work?
15 A It looks overall positive.
16 Q Do you think this review is fair by CRNA
17 Hooker?
18 A I think so.
19 Q If you turn to the next page, it's another
20 review from Alida Hooker, this one dated April 4,
21 2013?
22 A Yes.
23 Q Is that positive and do you think it's
24 fair?

Page 58

Page 60

1 A Yes.
 2 Q If you could turn back a few pages, at the
 3 bottom sometimes there are numbers. This one is Rush
 4 126 is the one I'm looking for. If you go into it a
 5 few pages, you'll find Rush 126.
 6 A Okay.
 7 Q They're not in numeric order they're in
 8 date order. It's the seventh page into the exhibit?
 9 A Okay.
 10 Q This appears to be a review or evaluation
 11 of you by Sheila Warren?
 12 A Yes.
 13 Q Dated February 14, 2013.
 14 And this rates you as satisfactory as
 15 well?
 16 A Yes.
 17 Q Did you think this review was fair by CRNA
 18 Warren?
 19 A Yes.
 20 Q This review also notes in the comment
 21 section some things for you to work on; right?
 22 A It appears that.
 23 Q Was this review accurate?
 24 A I don't recall like the exact details of

1 A Uh-huh.
 2 Q This one you did sign; right?
 3 A Yes.
 4 Q Is this review also satisfactory and
 5 positive of your work?
 6 A As indicated there, yes.
 7 Q It indicates at expected level; is that
 8 right?
 9 A Yes.
 10 Q Did you think this was fair, this review
 11 by CRNA Gawura?
 12 A To the best of my knowledge. If I had
 13 signed this, I might have seen it like, but yes.
 14 Q Do you have any hesitancy of saying this
 15 was a fair evaluation?
 16 A No. I don't think so.
 17 Q One more I want to ask you about is Rush
 18 112 at the bottom, and it's maybe ten pages from the
 19 back. There it is.
 20 You see this review, this evaluation is
 21 by Eva Fisher dated November 26; is that right?
 22 A Yes.
 23 Q 2012?
 24 A Yes.

Page 59

Page 61

1 that case. I also had gotten this later on in the
 2 month. Like this was dated the 2nd of or February 14,
 3 and I think I had seen this much later; so it's hard
 4 to recollect.
 5 Q Do you have any reason or any basis to say
 6 that any aspect of this review by CRNA Warren was
 7 inaccurate?
 8 A No.
 9 Q If you could turn to the next page, this
 10 appears to be an evaluation of you by Amy Gawura?
 11 A Yes.
 12 Q Dated February 7, 2013?
 13 A Yes.
 14 Q Is this also a positive review of you?
 15 A It appears to be.
 16 Q Did you think this was fair?
 17 A Like I said, I don't recall the actual
 18 dates; and I don't even know if I saw this since I
 19 haven't signed it.
 20 Q Any reason to believe it wasn't fair?
 21 A Not that I recall.
 22 Q If you turn to the next page, it appears
 23 to be an evaluation again by Amy Gawura dated
 24 January 24, 2013?

1 Q Does this review rate you as satisfactory?
 2 A As it's marked there, yes.
 3 Q And you signed this review?
 4 A Yes.
 5 Q Did you think this review was fair?
 6 A Yes.
 7 MS. SIEGEL: I'm going to object. No. Withdraw
 8 the objection.
 9 MR. LAND: Q I'm sorry. I have one more.
 10 It's Rush 121, and it's three to four pages from the
 11 back.
 12 A All right.
 13 Q This appears to be a review by a faculty
 14 member named Colino?
 15 A Yes.
 16 Q Dated October 8, 2012?
 17 A Yes.
 18 Q Do you know who that refers to, Colino?
 19 A One of the CRNAs. I think it's Katie
 20 Colino.
 21 Q Do you think this review is fair?
 22 A She didn't discuss this with me, so I
 23 didn't get a chance to like review it with her.
 24 I didn't sign it.

Page 62

1 Q So do you have any reason as you sit
2 here -- I think what you're saying is you don't know
3 if this was fair or not?

4 MS. SIEGEL: What page are we on?

5 A 121.

6 Yeah.

7 MR. LAND: Q I think you're saying you don't
8 know if this was fair or not, this evaluation?

9 A Yes.

10 Q Before you started in the residency
11 program, did you have any basis to believe that Katie
12 Colino had evaluated you in an unfair way?

13 A Before I started in the residency?

14 Q Yeah.

15 A Not that I recall.

16 Q You can put that exhibit aside.

17 We talked before the break about the
18 core of your claims, part of your claims is that you
19 believed that CRNAs falsified or fabricated portions
20 of critical evaluations of you during the residency
21 program period; right?

22 A Yes.

23 Q And we were talking about not all of them
24 were false or not all of them were fabricated in terms

Page 64

1 management?

2 A I might have made like a miscalculation.

3 There were some things that I didn't agree with.

4 Q And I'm wondering about the things that
5 you did agree with --

6 A Yes.

7 Q -- their criticisms of you and whether
8 that included any airway management issues?

9 A I think so.

10 Q What about instrument monitoring issues,
11 did you also agree with some CRNA criticism of you
12 with respect to that?

13 A I'd have to determine exactly which ones
14 because I think I had reviewed some of them.

15 Q Okay. So you are not sure if you agreed
16 with others criticism of your instrument monitoring
17 performance?

18 A Yes.

19 Q Is that what you're saying, you are not
20 sure?

21 A No. I'm not sure.

22 Q I think you're saying that some CRNA
23 evaluations of you that raised criticisms and rated
24 you as unsatisfactory during the residency program

Page 63

1 of their criticisms; right?

2 A Yes.

3 Q So you agree that in some cases the CRNAs
4 identified mistakes you had made that were problems
5 and that were accurate?

6 A Yes, some.

7 Q And we will look at some of the documents,
8 and I know you wrote a bunch of things about the
9 evaluations about the CRNAs. In some of them you
10 conceded you had some bad days; right?

11 A I believe so.

12 Q And that in some instances you conceded
13 that there were dosage, drug dosage issues that were
14 raised that were accurate about your work; right?

15 A Yes.

16 Q And that in some situations there were
17 airway management issues and criticisms of your work
18 that you were raised that you agreed were correct; is
19 that right?

20 A I don't recall. I think I mentioned in
21 the rebuttal section I don't recall those instances.

22 Q So you are not sure if you ever agreed
23 with the CRNA during the residency part of the program
24 that you made mistakes with respect to airway

Page 65

1 were fair and accurate?

2 MS. SIEGEL: I'm going to object. It
3 mischaracterizes the witness's testimony.

4 MR. LAND: Q Is that an accurate statement?

5 MS. SIEGEL: Can we have that back, please?

6 (Whereupon the last question
7 was read.)

8 Q Is that an accurate statement?

9 MS. SIEGEL: Same objection.

10 A No. I don't think some of them were fair
11 and accurate.

12 MR. LAND: Q Does that mean you're saying that
13 every unsatisfactory rating that you got from a CRNA
14 during the residency program was unfair or not
15 accurate?

16 A No.

17 Q So some of them were fair?

18 A Yes.

19 Q Some of them were accurate?

20 A Yes.

21 Q Were some of the mistakes that you made
22 during the residency program aspects of you having
23 difficulty applying knowledge that you knew in the OR
24 setting?

Page 66

Page 68

1 A Can you repeat that question?
 2 Q Were some of the mistakes that you made
 3 issues where you knew what to do, you just didn't do
 4 the right thing in the OR setting?
 5 A I just have to recall. I guess yes.
 6 MS. SIEGEL: Objection: Calls for speculation.
 7 Move to strike.
 8 MR. LAND: Q You don't know?
 9 A No.
 10 Q Were some of your points of contention
 11 with the CRNA evaluations of you, were they related to
 12 issues that you had a different judgment than the
 13 CRNA?
 14 A Yes.
 15 Q About like standard of care or what's
 16 appropriate care?
 17 A No, about their biases.
 18 Q I guess what I'm wondering is were there
 19 times when you just disagreed about medical judgments
 20 with the CRNA's criticism of you?
 21 A Yes.
 22 Q And sometimes you felt that they were
 23 making up facts that didn't happen?
 24 A No.

Page 67

1 Q Did you vocalize your disagreement with
 2 the CRNA's judgment about medical issues involving
 3 your work?
 4 A On occasion.
 5 Q Is that different than other students?
 6 A No.
 7 Q How do you know?
 8 A Well, just from when we have our talks
 9 with the SRNAs that I'm close with, how they would
 10 argue certain aspects of the anesthesia progression or
 11 how it's managed.
 12 Q Is part of the education as an SRNA to
 13 accept criticism from CRNAs and learn from it?
 14 A Yes.
 15 Q Did you think that you had difficulty
 16 doing that?
 17 A No.
 18 Q Did you ever tell any therapist or doctor
 19 that you did?
 20 A Accepting criticisms?
 21 Q Yeah.
 22 A No.
 23 Q No? You never discussed that with a
 24 therapist or a doctor, difficulty accepting criticism,

1 defensiveness to criticism?
 2 A No.
 3 Q Are you sure?
 4 A That I was defensive --
 5 Q Yeah.
 6 A -- when I was criticized? I don't recall
 7 mentioning that to the doctors, the school counselor
 8 that I spoke to on a regular basis, so no.
 9 Q What do you know about your performance
 10 during the clinical residency program compared to
 11 other students in the program?
 12 A I don't compare my work on a daily basis
 13 with them, but I have a strong feeling that I was
 14 average or even above some of my classmates. That's
 15 my appraisal.
 16 Q Based upon what information did you make
 17 that appraisal?
 18 A The tasks that I was assigned, the kinds
 19 of cases that I was assigned to, my evaluations on
 20 some of those complicated cases, certain specialized
 21 tasks that I was trusted to do; and I've asked them if
 22 they have done the same, and some of them haven't.
 23 Q Is that all that you know about other
 24 student's performance is asking them if they have done

Page 69

1 some of the same things you did and their responses to
 2 you?
 3 A Just on occasions they would show me their
 4 eval.
 5 Q Who showed you their eval?
 6 A Some of my classmates.
 7 Q Which ones?
 8 A I believe Miss Ebele had showed one to me.
 9 I don't recall my other classmates, but on occasions
 10 we have seen each others evals.
 11 Q So I'm wondering about you and seeing
 12 other students' evaluations, how many do you think
 13 you've seen in total?
 14 A Probably three.
 15 Q Other than what they have told you about
 16 procedures they have done and the three evaluations
 17 you've seen, what else do you know about other
 18 students' performance in the residency program?
 19 A Just my classmates talking about how other
 20 students performed.
 21 Q So students other than themselves?
 22 A Yes.
 23 Q Any other basis of information for how
 24 other students performed that you know?

Page 70

Page 72

1 A Not that I know of.
 2 Q So do you feel like you can actually
 3 compare in a thorough way your performance in the
 4 residency program to other students?
 5 A No.
 6 Q Is it accurate to say that you believe
 7 that Jill Wimberly started the unfair criticism of you
 8 during the residency program?
 9 A Yes.
 10 Q You are claiming that Miss Wimberly
 11 communicated to other CRNAs who followed her lead?
 12 A Yes.
 13 Q That they colluded together; right?
 14 A Yes.
 15 Q You've said that they agreed to evaluate
 16 you unfairly. Is that what you mean?
 17 A From what I've observed.
 18 Q What exactly do you believe that they
 19 agreed to do, the CRNAs?
 20 MS. SIEGEL: I'm going to object. It calls for
 21 speculation.
 22 You can answer.
 23 A I don't know.
 24 MR. LAND: Q What do you base your belief

Page 71

1 about that collusion on?
 2 A A couple of instances where I saw Jill
 3 talking to Eva almost in the discreet way whispering
 4 into, her ear and then looking at me and then
 5 whispering again, sort of implicating that they're
 6 talking about me and an occurrence that happened with
 7 Miss Eva Fisher showed up in Miss Wimberly's
 8 evaluation of me when it didn't happen on the occasion
 9 I was with her.
 10 Q You're saying Wimberly wrote about
 11 something that Fisher observed in an evaluation?
 12 A Yes.
 13 Q Do you know when that was?
 14 A Around June.
 15 Q June of 2013?
 16 A Yes.
 17 Q I asked you why you believed that CRNAs
 18 were colluding to provide negative and critical,
 19 unfair, untrue evaluations of you; and you told me
 20 about a conversation you saw between Jill Wimberly and
 21 Eva Fisher?
 22 A Uh-huh.
 23 Q And one evaluation of Jill Wimberly that
 24 included in your opinion information that Eva Fisher

1 observed; right?
 2 A Yes.
 3 Q Is there anything else that you base your
 4 allegation of collusion on?
 5 A I told Dr. -- Well, Dr. Kremer told me or
 6 sort of accused me that I am assuming the CRNAs are
 7 colluding against each other towards me; and I told
 8 him, yes, I believe that, and he didn't argue back.
 9 So that gave me the impression that he knew about this
 10 happening.
 11 Q Okay. Other than that conversation with
 12 Dr. Kremer, is there any other based evidence or
 13 basis, facts you have to support your belief that
 14 CRNAs were colluding against you?
 15 A Over the course of my researching about,
 16 you know, what's been happening to me, I have gotten
 17 comments from former students and current students
 18 about how they're being treated and similarities with
 19 my experience.
 20 Q You mean after you were dismissed from the
 21 program?
 22 A No, during and after.
 23 Q So other students told you things about
 24 the CRNAs that led you to believe that they were

Page 73

1 colluding against you?
 2 A Not mainly me, but people in my racial or
 3 like the minority group and protected class.
 4 Q So who told you that?
 5 A Miss Okonkwor, Miss Karen Kam, Mr. Hakeem
 6 Ellis, Mr. Kazim Fojolli (phonetic), Mr. Ben
 7 Gardner I'm trying to think of who else. That's the
 8 best of my recollection right now.
 9 Q What did Okonkwor tell you?
 10 A That on occasions she was with another
 11 student who is a minority. I'm trying to refresh my
 12 memory. Oh, actually that's a different SRNA. Well,
 13 in terms of the --
 14 Q I want to know what they told you about
 15 CRNAs colluding. Did Okonkwor say anything about it?
 16 A She had told me that she told Dr. Kremer
 17 she feels there is discrimination and that the CRNAs
 18 are very much a part of it and Dr. Kremer wrote or
 19 told her back, like I didn't know about this, why
 20 didn't you tell me. And she said, And what, be
 21 expelled from the program if I open my mouth. I would
 22 just rather keep it myself because I know you won't do
 23 anything.
 24 Q Do you know anything more about what

Page 74

1 Okonkwor said to you?

2 A Just similar impressions of how she was
3 graded versus how a white student was graded if she
4 was paired with another student from what I vaguely
5 recall.

6 Q What about Karen Kam, what did she say
7 about collusion of CRNAs?

8 A She was the one paired with another white
9 student; and she felt that she was grilled much more
10 harshly and was humiliated during the case whereas her
11 colleague, white classmate was left alone to perform
12 her work without being maybe questioned once and
13 basically left alone to do the case without much
14 interference.

15 Q Did she say that happened one time?

16 A Yes.

17 Q Which CRNA did she say?

18 A Jill Wimberly.

19 Q Is that the day before your negative
20 evaluation from Jill Wimberly?

21 A Yes.

22 Q In June of 2013?

23 A Yes, from what I recall.

24 Q Did Karen Cam say anything else about

Page 76

1 on one with CRNAs again; and he said a lot of
2 experiences there were negative.

3 Q In what way?

4 A I guess little things get pointed at which
5 weren't really issues but would show up in his eval,
6 like wearing pair of gloves even though they were
7 newly donned; and it was interpreted in a very
8 negative way in his evaluation even though it wasn't
9 how, you know, it turned out or how the occurrence
10 happened.

11 Q Anything else he said that was
12 discriminatory against him besides that?

13 A There were two other CRNAs who I don't
14 recall who they were, but he mentioned them. That was
15 a while back, so I don't recall.

16 Q Did he tell you which CRNA gave him
17 criticism on these little things like gloves?

18 A I don't recall.

19 Q But it was one CRNA who did that?

20 A I believe so.

21 Q What about is it Fojolli?

22 A Fojolli.

23 Q What did Fojolli say about collusion among
24 CRNAs?

Page 75

1 collusion between CRNAs?

2 A She would mention comments. I don't
3 recall the exact detail of who was close to each other
4 and would likely influence their judgment of us. But
5 I don't know the -- I can't really say the exact
6 detail of what she said. She intimated to me?

7 Q What about Ellis, what did Ellis say about
8 collusion among CRNAs?

9 A Same comments of how he was being treated;
10 but also when he had participated in the internal
11 investigation, he had told me afterwards that he
12 voiced his concern of discrimination.

13 Q What was his concern about discrimination?

14 A That he feels he is disparately treated
15 compared to this other nonminority classmates.

16 Q In what way?

17 A He didn't go into it, but he said during
18 an internal investigation he voiced that concern.

19 Q So you don't know what he thought was the
20 different treatment he received, what even the issue
21 was?

22 A There were instances when he returned from
23 being away from Rush after being on an off-site for a
24 while coming back, and he started getting paired one

Page 77

1 A With him it was a CRNA who had already
2 left; and he said that he had been put under scrutiny,
3 more scrutiny because of one complaint by a CRNA which
4 was later I guess unfounded or was disregarded because
5 he was assigned to Dr. Wiley then; and Dr. Wiley had
6 said you are okay. So that previous issue really was
7 probably a one-time incident. But he felt there were
8 some treatments that were not fair towards him.

9 Q By one CRNA?

10 A Several others. He didn't really
11 elaborate.

12 Q I'm not sure what you mean. He said there
13 were multiple CRNAs who had mistreated him but he
14 didn't say who or how?

15 A I don't recall the names because with the
16 other students, the CRNA names were, you know, kind of
17 mixed; so I'm not sure of specific ones but
18 Mr. Fojolli.

19 Q Are you sure he was referencing more than
20 one CRNA as creating problems for him in a
21 discriminatory way?

22 A That's what he intimated to me.

23 Q That's what he what?

24 A That's what he indicated to me.

Page 78

Page 80

1 Q What about Gardner and collusion among
2 CRNAs, what did he say to you?
3 A That he was behind a group of CRNAs and
4 they were talking about different SRNAs and how they
5 were going to treat them and a comment made by one
6 CRNA saying, well, we are the gatekeepers and we
7 determine who gets through or not.
8 Q Is that true?
9 MS. SIEGEL: I'm going to object. Calls for
10 speculation.
11 MR. LAND: Let me ask it a different way.
12 Q Do you believe it's true that the CRNAs
13 act as gatekeepers as to who gets through the SRNA
14 program?
15 A I have a strong sense that that was
16 happening.
17 Q Isn't that kind of their role in
18 evaluating SRNAs and whether their performance is
19 satisfactory or unsatisfactory?
20 A If they were not tainted with their own
21 motives.
22 Q But that's not what I'm asking. I'm
23 asking isn't that their role, not what their motives
24 are. But isn't that their role?

Page 79

1 A Their role is to be fair with us in their
2 treatment and grading.
3 Q But to evaluate and grade and identify
4 unsatisfactory performance if they see it, right?
5 A In what is fair.
6 Q Okay. So you are agreeing with me, as
7 long as it's fair?
8 A As long as it's fair.
9 Q Other than the comments from those five
10 other students and other things you've told me about
11 why you believe there was collusion among the CRNAs to
12 unfairly criticize your performance, is there any
13 other reason you believe that that's what happened to
14 you?
15 A More CRNAs or more SRNAs in the later
16 program or later batch had told me their own
17 experiences.
18 Q You are saying other students besides the
19 ones you've identified talked about their own
20 experiences?
21 A Uh-huh, yes.
22 Q Involving CRNA collusion?
23 A Yes.
24 Q To unfairly criticize people?

1 A Yes.
2 Q How many?
3 A A later batch. We have Mahalia and
4 Dwight.
5 Q What did Mahalia say?
6 A Just the harassment she felt that Wimberly
7 treated her is I believe -- That's mostly what I
8 recall.
9 Q So she said that Jill Wimberly harassed
10 her and didn't treat her well?
11 A Yes.
12 Q What about Dwight, what did Dwight say
13 that you interpret as indicating collusion among CRNAs
14 to unfairly evaluate SRNAs?
15 A Dwight had mentioned to me how he wrote an
16 eval that was disparaging, not disparaging but
17 negative towards one CRNA because of his experience
18 with her; and I don't remember the exact details.
19 Q So Dwight told you he wrote a written
20 evaluation of a CRNA that was critical?
21 A Uh-huh, yes.
22 Q And that's all you remember Dwight saying
23 to you?
24 A He made the comment of how he felt that he

Page 81

1 was treated differently.
2 Q Is that all you remember either Dwight or
3 Mahalia saying about CRNA treatment of SRNAs?
4 A Well, with Mahalia there is multiple
5 infractions; but the gist of it is she mostly had
6 negative instances with Jill, and she brought this to
7 Dr. Kremer's attention, but she kept getting assigned
8 to her.
9 Q Do you know if nonminority students had
10 problems with Jill Wimberly?
11 A I don't recall. I don't. Yeah. I don't.
12 Q Does that mean you don't know?
13 A I don't know.
14 Q Which CRNAs with respect to you and
15 evaluations of you do you believe Jill Wimberly
16 colluded with to give you negative evaluations? You
17 mentioned Eva Fisher.
18 A I can't say for sure.
19 Q Why not?
20 A I guess there is no written, just more of
21 an observation, but nothing outright to say that she
22 did approach them.
23 Q When you say just an observation, you mean
24 your own observation?

Page 82

1 A Yeah.

2 Q Your observation of what leads you to
3 believe that others colluded with Jill Wimberly and
4 Eva Fisher?

5 A From my recollection, just one other CRNA
6 who wrote me up after Jill had relieved her. I'm
7 trying to recall because I was relieved by Ray from
8 that case, and Jill complained to that CRNA who I was
9 with that morning that I didn't return even though Ray
10 had relieved me.

11 And so I believe I got a negative
12 evaluation from that other CRNA even though I don't
13 recall anything that she said would have been wrong
14 during that day in our case.

15 Q Who was that other CRNA?

16 A Lea Forester.

17 Q Anything else that leads you to believe
18 that there was collusion amongst CRNAs?

19 A So in addition to those students --

20 Q Let me back up. Is there any other people
21 that you believe, other CRNAs who colluded with Jill
22 Wimberly and Eva Fisher?

23 A Is there any other CRNAs that colluded
24 with --

Page 83

1 Q Yeah.

2 A I don't know.

3 Q Wasn't Jill Wimberly new as a CRNA when
4 you were in residency in May and June of 2013?

5 A From what I recall, yes.

6 Q Was Eva Fisher new as a CRNA?

7 A No.

8 Q Why would other CRNAs follow Jill Wimberly
9 in her effort to unfairly criticize you; do you know?

10 MS. SIEGEL: Calls for speculation.

11 A I have no idea.

12 MR. LAND: Q Did you say you have no idea.

13 A No.

14 MS. SIEGEL: I move to strike. That calls for
15 speculation.

16 MR. LAND: Q How many times did you actually
17 work with Jill Wimberly during clinicals from May,
18 2013 through August of 2013?

19 A I believe there were two full occasions
20 and two other times I was assigned to her, but I got
21 sick on the fourth time I believe.

22 Q So two times where you actually worked
23 with her in that time?

24 A Yes.

Page 84

1 Q And two other times where you were
2 assigned to her but didn't end up working with her?

3 A Yes. The one time is when Ray relieved me
4 from being assigned to her. I was sent home, and then
5 the fourth time is when I had to call in the day
6 before I was assigned the next day to her; and, yeah,
7 I didn't come in that day.

8 Q Did you receive written evaluations from
9 Jill Wimberly for both times you worked with her
10 during that time, May, 2013 to August, 2013?

11 A Yes.

12 Q One of them was positive; right?

13 A Yes.

14 Q So it was only one time when she was
15 critical of you during that time period?

16 A In written form, but she reported me to
17 Lea because I didn't show up even though Ray had
18 relieved me.

19 Q Then Lea wrote you up, is that what you're
20 saying?

21 A I believe she wrote me a negative eval
22 later on.

23 Q About your not showing up?

24 A No, about the case that we had, not

Page 85

1 necessarily that day, I think another day.

2 Q So I think you're saying you didn't get a
3 negative critical evaluation of the day when Jill told
4 Lea you didn't show up when she was in incorrect but
5 that that influenced Lea's later evaluation of you on
6 a different day, is that what you're saying?

7 A I believe so, yes.

8 MR. LAND: Mark this as Exhibit 3.

9 (Marcial Deposition Exhibit No. 3
10 was marked for identification.)

11 Q Exhibit 3, do you recognize this document?

12 A Yes.

13 Q So it's entitled Plaintiff's Responses and
14 Objections to Defendants' First Set of
15 Interrogatories. Do you see that?

16 A Yes.

17 Q These are your responses to my client's
18 questions called interrogatories. And if you look at
19 the last page of the exhibit, that's your signature;
20 right?

21 A Yes.

22 Q Indicating that you are verifying that
23 these responses are accurate and true?

24 A Yes.

Page 86

Page 88

Q Could you turn to Page 17. If you look, there is paragraph enumerated C. Do you see that?

A Uh-huh, yes.

Q It says: On or about blank, 2013 Miss Marcial told Dr. Kremer that she believed she was being subjected to harder or more frequent questioning during her cases than other SRNAs resulting in unfair, negative evaluations and that other SRNAs had expressed surprise at the frequency and difficulty. Do you see that?

A Yes.

Q And it says she pointed out to Dr. Kremer that the suspect group of CRNAs included defendant Wimberly, Eva Fisher, Angela Keehn, Amy Gawura and Lea Forester. Do you see that?

A Yes.

Q Do you know when you told Dr. Kremer that?

A I believe right around July before, leading up to my leave of absence.

Q Had Angela Keehn evaluated you as of July of 2013?

A I don't recall who I've had that time so far.

Q Isn't this paragraph intended to explain

itself as opposed to giving you a critical evaluation?

A There was an occasion when she was questioning me quite a bit; and then I later was showed the evaluation, and I had to refute them point by point, that my suggestions were valid. I think that was -- Yeah. That was with her.

Q What do you remember about her questioning you quite a bit?

A There was a patient who told me about -- I'm not sure if this is from this instance but where a patient who came in for port placement as an outpatient procedure ended up being a general case; and so I suggested that we use Epolamine which is more for general cases.

Q What was that you suggested using?

A Epolamine patch.

Q Okay.

A And she said that that was a poor -- like in the eval, that was an inappropriate plan.

Q What did she saying say during the case itself that you thought was overly critical or harder and more frequent questioning?

A I think during cases I was being questioned from time to time about different like, you

Page 87

Page 89

that you thought that these are the people who were treating you harshly and subjecting you to harder and more frequent questioning during the cases?

A Yes.

Q Is it possible that Angela Keehn hadn't even evaluated you or worked with you at that time?

A I don't recall. Like every day that I was there I believe, I had been with her on one of those days; and there is certain times when I hand them an evaluation and they don't return it so.

Q What do you remember about Angela Keehn evaluating you in 2013 or talking to you or asking you questions during a case?

A I don't recall like my encounters with her then because I am not sure if I'm recalling stuff that happened in 2014 or 2013 just because at that time the distress I was going through, I just was not sleeping enough.

Q So there may not have been a time in 2013 when Angela Keehn treated you poorly in an evaluation or in a case?

A Yeah. I don't recall exactly.

Q What about Lea Forester, do you recall any time where she treated you poorly during the case

know -- I think it was about air embolism, and she had asked me about the symptoms. But in the evaluation, I think she wrote that I couldn't answer what the treatment was, so she had switched it around or like didn't really put down the right questioning them.

Q So you are concerned with how she treated you during the case and that she asked you a lot of questions?

A Not necessarily then. But when I saw the eval of how she translated my answers and my actions --

Q So you're --

MS. SIEGEL: She is still answering.

MR. LAND: I'm sorry.

Can we have the question back and the witness's answer.

(Whereupon the requested portion of the record was read.)

A -- then I felt that they weren't lining up.

MR. LAND: Q Did you have a concern about how she addressed you during the case itself?

A Not right then.

Q What about Eva Fisher, did you ever have a

Page 90

1 concern about how she, Eva Fisher addressed you during
2 a case itself versus what she wrote in an evaluation?

3 A Not during a case.

4 Q With respect to Amy Gawura, would you turn
5 to Page 19. In the third full paragraph on this page,
6 three-quarters of the way down, the paragraph, the
7 sentence that starts I perceived Miss Gawura, do you
8 see that?

9 A Yes.

10 Q It says: I perceived Miss Gawura as tough
11 but fair, and I had decided to approach her to help
12 me. Do you see that?

13 A Yes.

14 Q Is that an accurate description of how Amy
15 Gawura treated you during cases?

16 A My appraisal then was yes.

17 Q Was there ever a time where during a case
18 she didn't treat you properly?

19 A Yes. There was different instances, not
20 this one.

21 Q What I'm asking you is during the case
22 itself as opposed to her evaluation after the case,
23 was there ever a time where during the case itself she
24 talked to you or asked you questions or approached you

Page 91

1 in a way that you thought wasn't appropriate?

2 A Not during this particular case.

3 Q Was there some other case where she talked
4 to you poorly during the case itself?

5 A Yes.

6 Q What do you remember about that?

7 A It was I believe surgery for a breast
8 resection type of surgery, and it was a younger
9 patient; and I was in the process of intubating the
10 patient, so I had the blade in my one hand. And I'm
11 not sure if she held me; but clearly she told me, If
12 you as so much chip that patient's teeth, I will knock
13 yours myself.

14 And this was witnessed by the surgeon
15 and his resident who reacted saying, Did you hear that
16 CRNA threaten that student?

17 Q When was that?

18 A I believe that was after my return from my
19 leave.

20 Q Other than that one comment, was there
21 anything else in that case that you thought was
22 inappropriate that she said to you?

23 A Not to my recollection.

24 Q Other than that case, are there any other

Page 92

1 cases where you thought that Amy Gawura said anything
2 inappropriate to you during the case itself?

3 A No.

4 Q During May of 2013 through the time you
5 took your leave of absence in August of 2013, there
6 were other CRNAs who treated you or worked with you
7 and evaluated you; right?

8 A Yes.

9 Q Did any of them treat you poorly during
10 that case itself?

11 A Not to my recollection.

12 Q So between May of 2013 and August of 2013,
13 I think you are saying the only times anyone talked to
14 you poorly during the case itself was Jill Wimberly on
15 June 20, 2013; is that right?

16 A During the case? Yes.

17 Q So you have issues --

18 A No. I'm sorry. Also Miss Eva.

19 Q Miss Eva Fisher?

20 A Yes. I'm trying to recall.

21 Q Let me make sure I understand what you're
22 saying. During a case between May, 2013 and August of
23 2013, you're saying Eva Fisher said something or
24 addressed you in an inappropriate way during the case?

Page 93

1 A Not the operative case but preoperatively
2 while we were examining a pediatric patient.

3 Q What happened?

4 A I had discretely -- Because the patient
5 was here, we were on the head part of the patient; and
6 Eva -- I was talking to the parent; and I said -- It's
7 one of the things I was told by Lea Forester and also
8 in our lectures to ask to gauge the kid or the child's
9 readiness or gauge if they have any type of separation
10 anxiety, to ask. So I discretely asked the parent,
11 Has your child been by herself or himself before, and
12 even Eva loudly interjected, Whoa, Whoa, Whoa. We
13 don't ask those questions, and you're scaring the kid
14 is from what I recall.

15 And I didn't really argue back, but I
16 thought that it would have been better handled if she
17 pulled me aside and told me what I did wrong when I
18 was just following what I was told in the previous
19 encounters with Lea who was a pediatric CRNA as well.

20 Yeah. So that was a little -- It kind
21 of undermined me in front of the parent that I
22 apparently did something wrong.

23 Q Is that the only thing Eva Fisher did
24 during that case in that preoperative examination that

Page 94

1 you thought was inappropriate?

2 A Well, during the surgery, I didn't really
3 think it was any issue; but she made a big deal out of
4 me removing the expiratory part of the ventilation
5 circuit even though it was maybe a second that it came
6 off and I reattached it.

7 And just from my recollection, I
8 thought that the case was already done and they were
9 motioning to transfer the child to his crib; and so it
10 wasn't being used. And I didn't think it was
11 inappropriate then, but she reacted strongly to it and
12 wrote me up later on in the evaluation negatively
13 pertaining to that fact.

14 Q When you say she made a big deal about
15 that, you mean she told you not disconnect it and to
16 reconnect the ventilation circuit?

17 A Yes, this one tube in the circuit. It's
18 like Stop, put it back.

19 Q She said those words. Did she do anything
20 else?

21 A No. She was attending to the patient, but
22 it's more than the negative eval that followed which
23 Dr. Kremer kept pointing out what I did.

24 Q Was there anything else that Eva Fisher

Page 96

1 talked to you the way she did on June 20, 2013 which
2 we will look at, do you think that was because of your
3 age or your race or your national origin?

4 A I have a sense it was my race with her.

5 Q Why?

6 A Because of the prior experience that my
7 other colleague had with her and -- yeah, mostly that
8 she had behaved differently towards a white classmate
9 versus her.

10 And going forward, Miss Ebele and
11 Mr. Hakeem also felt that she behaved that way towards
12 them more harshly than our other classmates.

13 Q Did you ever talk to any nonminority
14 classmates about what they thought of Jill Wimberly's
15 treatment of them?

16 A I didn't talk to them, but I was part of a
17 text group; and my white classmates would say that I
18 really don't have a problem with them. But I'm not
19 sure if it was Kathy who said that, I know she hates
20 Asians, but I'm white, so I don't have a problem with
21 her.

22 Q How many white classmates of yours were on
23 the text message stream that you're talking about?

24 A Two.

Page 95

1 did in that case that you thought was inappropriate
2 during the case?

3 A Not that I recall.

4 Q So other than the one time Jill Wimberly
5 on June 20, 2013 criticized you and the things in the
6 case that you think are inappropriate and the things
7 with Eva Fisher that you just described, is there
8 anything else that any CRNA did between August of 2013
9 and May of 2013 that you thought was inappropriate?

10 A No, not that I recall.

11 Q How would you remember if there were any
12 other instances?

13 A On occasions I would write down at the end
14 of the day and other times just reviewing the
15 evaluations later on. Like after, I guess mostly
16 after I was dismissed and trying to recollect what had
17 happened.

18 Q Did you think that Eva Fisher talked to
19 you that way those two times in that one case because
20 of your race or your national origin?

21 A No.

22 Q Or your age?

23 A No.

24 Q What about with Jill Wimberly when she

Page 97

1 Q Did the other one besides Kathy say
2 anything about Jill Wimberly's perception of Asians?

3 A I don't recall her comments.

4 Q Did the other white classmate say anything
5 about what she thought of Jill Wimberly?

6 A Just that -- Oh, no. I'm not sure now.

7 Q So other than one white classmate saying
8 something on a text message about Jill Wimberly, do
9 you have any basis to know what other white classmates
10 thought about Jill Wimberly's treatment of them?

11 A Well, Kim who was with her apologized to
12 Karen for the way she was treated; but she recognized
13 she didn't have any problems with her even in the
14 later encounters with Jill.

15 Q Kim Huntzinger --

16 A Yes.

17 Q -- said that to Karen Cam?

18 A Yes.

19 Q But not to you; right?

20 A Karen told me of what Kim said.

21 Q Other than that, do you have any other
22 information about white classmates' perspective of
23 Jill Wimberly's treatment of them?

24 A No.

Page 98

1 Q Let's talk about Karen Cam for a minute.
 2 Do you know what her national origin and race are?
 3 A She is Filipino.
 4 Q And that's your national origin; right?
 5 A Yes.
 6 Q So she is Asian like you are as well?
 7 A Yes.
 8 Q Is she also a similar age to you?
 9 A Yes.
 10 Q And she passed through the program; right?
 11 A Yes.
 12 Q And do you have any idea why she passed
 13 through the program and you didn't?
 14 A No.
 15 Q Have you ever asked Karen about that?
 16 A I don't think we discussed it, no. It was
 17 sort of a sensitive topic.
 18 Q Could it be because her clinical
 19 performance was better than yours?
 20 MS. SIEGEL: Calls for speculation.
 21 A I can't really gauge that because I've
 22 never been with her.
 23 MR. LAND: Q What about Anthony Nguyen? I
 24 might be mispronouncing it.

Page 99

1 A Nguyen.
 2 Q Is that how you say it?
 3 A Yes.
 4 Q How do you spell it?
 5 A N-g-u-y-e-n.
 6 Q Do you know Anthony?
 7 A Yes.
 8 Q Do you know what his national origin or
 9 race are?
 10 A I believe he's Vietnamese.
 11 Q Did he pass through the program?
 12 A Yes.
 13 Q Do you know why he was treated differently
 14 than you?
 15 MS. SIEGEL: Calls for speculation.
 16 A No.
 17 MR. LAND: Q Well, you do know he was treated
 18 differently than you; right?
 19 A I never really interacted with him a lot,
 20 and I don't know how his performance was.
 21 Q By that I mean you know that he passed
 22 through the program and you did not?
 23 A Yes.
 24 Q And you don't know why that happened?

Page 100

1 A Well --
 2 MS. SIEGEL: Same objection.
 3 A Yeah. I don't know. I don't know why.
 4 (Whereupon a brief recess was had,
 5 after which the deposition of
 6 Ms. Marcial continued as
 7 follows.)
 8 (Marcial Deposition Exhibit No. 4
 9 was marked for identification.)
 10 MR. LAND: Back on the record.
 11 Q I meant to ask you after you left Rush's
 12 program, did you resume working as an ICU nurse?
 13 A Yes.
 14 Q When did you start doing that?
 15 A I think when I was on leave I started
 16 working again for that five-month period that I was on
 17 leave of absence, and then I believe I took a leave
 18 from the hospital from my ICU work and focused on the
 19 return to my residency. Then I think I started again
 20 when I was dismissed, like the week of my dismissal.
 21 Q And where are you employed as an ICU
 22 nurse?
 23 A Lutheran General Hospital.
 24 Q That's where you had worked before you

Page 101

1 enrolled in the SRNA program?
 2 A Yes.
 3 Q And you're still working there now?
 4 A Yes.
 5 Q I hand you what's been marked Exhibit
 6 Number 4. Exhibit 4 is a compilation of evaluations
 7 from the May, 2013 through August, 2013 time period?
 8 A Yes.
 9 Q So this is when you were in the residency
 10 program that we were talking about earlier?
 11 A Yes.
 12 Q The residency portion of the program?
 13 A Yes.
 14 Q And the first two pages of this appear to
 15 be a summative evaluation of you during that time
 16 period?
 17 A Yes.
 18 Q Compiling examples of some of your
 19 evaluative comments, evaluative comments about you;
 20 right?
 21 A Yes.
 22 Q But not all?
 23 A Not all of them.
 24 Q Was this ever shared with you at the time

Page 102

1 when you were enrolled at Rush?

2 A Not right there, not right then, not right
3 away after they wrote this. It was more towards the
4 part of it towards my leading up to my leave of
5 absence, so not contemporaneously I'm saying.

6 Q But it was shared before you went on your
7 leave of absence?

8 A Some of them.

9 Q I'm talking about the summative
10 evaluation, this two-pager that's at the beginning of
11 Exhibit 4.

12 A I believe so.

13 Q When did you start your leave of absence?

14 A I think it was the first week of August.

15 Q If you look at the top of this first page,
16 it references an evaluation was done on July 30, 2013.
17 Do you see that?

18 A Yes.

19 Q So this was shared with you pretty close
20 in time then, right, to when it was prepared if it
21 included July 30 and you went on leave the first week
22 of August?

23 MS. SIEGEL: When you say this, what are you
24 referring to?

Page 103

1 MR. LAND: The summative evaluation. Thank
2 you.

3 A Can you repeat the question?

4 MR. LAND: Q I'm wondering when this summative
5 evaluation was shared with you. The fact that it
6 includes a reference to a July 30, 2013 evaluation,
7 I'm wondering if that leads you to recognize you
8 received this very soon after it was prepared but
9 before you went on your leave of absence the first
10 week of August?

11 A This first part I recognize before my
12 leave of absence.

13 Q By the first part, you mean this two-page
14 document, the summative evaluation?

15 A Well, the whole summative evaluation is
16 what you're referring to.

17 Q Yeah. So this is a group exhibit --

18 A Yes.

19 Q -- that we compiled for purposes of this
20 deposition. The first two pages are one document?

21 A Yes.

22 Q That's what I'm asking you about. You
23 received that?

24 A Yes.

Page 104

1 Q I want to use that as a reference tool to
2 refer to some of the evaluations that come behind it?

3 A Okay.

4 Q That's the point of it being here. So if
5 you turn to the second page of the summative
6 evaluation, there is a reference, the last bullet
7 point says:

8 5/10/13. Great job today. Asked
9 appropriate questions, easier to
10 improve stills.

11 J. Wimberly. That indicate that
12 Jill Wimberly evaluated on May 10,
13 2013.

14 Right?

15 A Yes.

16 Q If you turn into the rest of this
17 document -- Rush 10 is the page number, and these are
18 numbered sequentially I believe -- does this appear to
19 be the evaluation that Jill Wimberly completed on
20 May 10, 2013 for you?

21 A Yes.

22 Q And the scores on this evaluation are all
23 either satisfactory or outstanding; right?

24 A Yes.

Page 105

1 Q And it includes in the comments the quoted
2 language I just read; right?

3 A Yes.

4 Q Would you agree this evaluation from Jill
5 Wimberly is fair and accurate?

6 A I didn't see this at the time that she
7 filled it out. I haven't signed it. I didn't see it.

8 Q Looking at it now, do you think it's fair,
9 a fair evaluation of what you did that day?

10 A I felt I performed strongly that day, so I
11 think it's pretty accurate.

12 Q That's what this evaluation indicates;
13 right?

14 A Yes.

15 Q So this was one of the two days that you
16 worked with and were evaluated by Jill Wimberly;
17 right?

18 A Actually I just recalled that I had a
19 third full day with her in January, so there is
20 actually five encounters with her.

21 Q What I meant was this is one of the two
22 times you worked with Jill Wimberly during 2013 in the
23 residency program?

24 A Yes, in 2013.

Page 106

1 Q When you say five, you mean one in 2014,
2 two actual working together experiences in 2013, and
3 the other two that were scheduled but didn't happen;
4 right --

5 A Yes.

6 Q -- that you talked about before?

7 A Yes.

8 Q So this May 10th, 2013 evaluation reflects
9 one of the two times you worked with Jill Wimberly in
10 the 2013 residency period?

11 A Yes.

12 Q If you look back now at the summative
13 evaluation, the second page, the next bullet above
14 5/10/13 says 5/14/13?

15 A Yes.

16 Q And refers to an evaluation that was
17 prepared by Judy Wiley I believe; is that right?

18 A Yes.

19 Q If you turn to page Rush 11, those two
20 pages appear to be the evaluation prepared by Judy
21 Wiley about May 14, 2013?

22 A Yes.

23 Q This is a slightly different form, but all
24 of the evaluative ratings are either satisfactory,

Page 108

1 positive and fair?

2 A Well, it's positive; but I don't recall
3 discussing with her the ratings on like the lower
4 satisfactory ratings here; so I can't say that it's
5 entirely, that I entirely agree with her ratings.

6 Q I was asking if the evaluation is fair,
7 and you are saying you are not sure what you think
8 about the ratings that are circled as 2's. Is that
9 what you're saying?

10 A Yes, because this was not really presented
11 to me and discussed as to how I got that 2.

12 Q So does that mean you don't have a
13 position on whether it's fair or unfair?

14 A I have to be able to I guess discern, get
15 her opinion on how she rated me fair. So I can't
16 really comment on the fairness of it.

17 Q Does that mean you don't look at it and
18 think it's unfair?

19 A I don't think it's unfair.

20 Q If you go back to the summative
21 evaluation, the next bullet up is a June 11, 2013
22 reference?

23 A Yes.

24 Q Do you see that?

Page 107

1 above level expected, or outstanding; right?

2 A Yes.

3 Q So this was a positive evaluation of you?

4 A Yes.

5 Q Did you think it was fair and accurate?

6 A To the best of my knowledge. Yes. I
7 reviewed this through Typhon.

8 THE REPORTER: You reviewed this through --

9 THE WITNESS: Typhon. It's an online
10 evaluation.

11 MR. LAND: Q If you look back at the summative
12 evaluation again, the second page, the next bullet
13 going up the list is June 3rd, 2013, evaluation from
14 A. Hooker who I think is Alida Hooker?

15 A Yes.

16 Q And if you can, find that evaluation at
17 Rush 14.

18 Do you see this evaluation from CRNA
19 Hooker?

20 A Yes.

21 Q Are all of the ratings satisfactory or
22 outstanding in the numeric categories?

23 A It appears that, yes.

24 Q And did you view this evaluation as

Page 109

1 A Yes.

2 Q And that relates to a review from
3 Elizabeth Fisher?

4 A Eva.

5 Q I'm sorry, Eva Fisher.

6 You can find that evaluation on Rush
7 16. Now, this is an evaluation that includes some
8 unsatisfactory ratings; right?

9 A Yes.

10 Q Several of them?

11 A Yes.

12 Q And I believe this is one evaluation that
13 you took issue with at the time?

14 A Correct.

15 Q If you could keep this Exhibit 4 and this
16 page in front of you but also pull out what was marked
17 as Exhibit Number 3, your responses to interrogatories
18 and turn to Page 24. Do you see the reference in
19 what's enumerated number 9 allegation and then
20 reference to June 11th as reported by evaluator
21 E. Fisher?

22 A Yes.

23 Q What follows I believe is your explanation
24 of what you disagreed with about this evaluation; is

Page 110

1 that right?

2 A Yes.

3 Q I just want to have them both in front of
4 us and ask you some questions.

5 A Okay.

6 Q So on the evaluation itself at the top, it
7 is handwritten next to room preparation and equipment
8 check, Wrong size ETT for child. Do you see that?

9 A Yes.

10 Q Was that accurate?

11 A Not entirely from my recollection because
12 I had a guide which was a pre made, personalized guide
13 for this particular patient. So I based my
14 preparation with that particular patient and I
15 followed that, and she struck that down for some
16 reason.

17 Q In your response in Exhibit 3, did you
18 reference this issue about whether the ETT was the
19 wrong size for the child?

20 A I referenced that I had carefully prepared
21 for the first and had no recall of difficulties, that
22 I was confident that my preparation was appropriate.

23 Q Where are you referring to in your
24 response?

Page 111

1 A I had carefully prepared for the first and
2 recalled no difficulties.

3 Q So I don't see a reference there to what
4 size was used for the ETT?

5 A Because it was not raised then, and so
6 this was -- I got this much later; and when I was
7 rebutting it, I know that my preparation was adequate.

8 Q Do you know what sized ETT you used that
9 day?

10 A I have no recollection exactly. Like I
11 said, they prepared a document for that particular
12 patient which I followed.

13 Q Do you have that document?

14 A I might be able to retrieve it somewhere,
15 but I have to -- I don't know the name of this
16 patient.

17 Q So I guess what I'm wondering is how do
18 you know that it's incorrect that you used the wrong
19 sized ETT if you don't know what size you used?

20 A I can't recall the exact size right now,
21 but my recollection was that she had her own
22 preference for this particular patient which does not
23 necessarily follow the standard or the reference that
24 I used as a guide for my prep.

Page 112

1 So sometimes some CRNAs have their own
2 preferences of the size, and it's not necessarily
3 wrong. It's just another option because when
4 preparing ET tube sizes, we prepare different sizes.
5 And so if she just wanted to just have that one size,
6 she could call it as a wrong ET tube size for child
7 even though the proper sizings are there, the
8 different options are there.

9 Q Let me refer to the bottom of Page 24 in
10 the interrogatory response, Exhibit 3 to your left,
11 the paragraph that starts at the bottom --

12 A Yes.

13 Q -- this is you saying the second case as
14 scheduling changed involved a premature infant,
15 27 weeks old delivered two days before?

16 A Yes.

17 Q There was no time to prepare for this
18 emergent situation?

19 A Yes.

20 Q Wasn't it this child --

21 A No.

22 Q -- that the ETT reference is for?

23 A No. It's a different child. The first
24 patient was a 6-year old. There is two cases here.

Page 113

1 Mass excision of a 6-year old if you look at the case
2 above, and the second case is an explore lap of a
3 1-day old. So those are two different patients.

4 Q How do you know you didn't use the wrong
5 sized ETT for the second patient, the 27-week old?

6 A Oh, I didn't prepare for that. She is
7 commenting --

8 Q How do you know which child she is
9 referring to when she says wrong sized ETT for child?

10 MS. SIEGEL: Could we have the question back?
11 (Whereupon the requested portion
12 of the record was read.)

13 MR. LAND: Maybe I should start over.

14 Q How do you know which child is being
15 referred to by this comment of wrong sized ETT for
16 child?

17 A Because I only prepared for the 6-year
18 old, and the second child was an add-on. I didn't
19 prepare for that.

20 Q Did you use an ETT for the second child?

21 A She did because she prepared for that
22 child. I didn't. I was just an observer.

23 Q So you didn't do any work?

24 A No.

Page 114

Page 116

Q Or make any decisions on the second child?

A No. This was a very complicated case of a premature infant, so I was just an observer.

Q Okay. The next written comment here is I think took circuit off after extubation?

A With baby having apneic spells.

Q Is that referring to what you talked about earlier?

A Yes.

Q About Miss Fisher commenting on you disconnecting the circuit?

A Yes.

Q So that happened; right?

A It did, but not the way she portrayed it.

Q What part is wrong about what she wrote there in your view?

A It was already a while that we recovered the baby. They were motioning to transfer the baby to the crib, and so I acted to remove part of the circuit because then we're turning over the room so I could come with them to transfer the baby back to the neonatal ICU. So they weren't using the mask that was attached to the circuit, so it was not affecting -- The baby was having apneic spells.

remove and then put back, so it didn't affect the patient's recovery at any point.

Q But then the patient stayed with the circuit connected for a period of time after that; right?

A No. They just observed briefly, and then they moved on to transferring the patient to the crib from my recollection.

Q Further down on this evaluation under clinical judgment there are several I ratings?

A Yes.

Q Did you address those in your explanation in this interrogatory response on Page 24 and 25?

A Yes. In this very short, case there was no request for fluids. There is no time for preparation for this emergent situation. Many of the criticisms appear to be directed towards preparation, unsatisfactory ratings, and room prep, equipment check, protect patient from iatrogenic complications. In this very short case, there was no request for fluids. The CRNA made decisions in this complicated case.

So if she was referring to my participating in this, I didn't because she mostly ran

Page 115

Page 117

The way she related here is that they were actively reviving the patient who was having apneic periods when I removed that circuit, that part of the circuit.

Q Well, you added some words there that aren't here, right? You said they were actively reviving someone. That's not written here, is it?

A Well, she was saying with baby having apneic spells. That was initially as the baby was being recovered; but later on when they were motioning to transfer the baby, he wasn't having apneic spells anymore.

Q So you're saying you took the circuit off when the baby was done with the apneic spells?

A Well, when we assumed that the baby was stable to move out of the crib or move out of the OR table into his crib which means that he's recovered his own breathing.

Q So Miss Fisher disagreed with you about that step you took then. She told you not to do it?

A Well, she told me to stop because then they decided to hold back; and I'm not sure if it's because they thought he was apneic and decided to observe some more. But that act took one second to

the case for the second part.

In the first part there was not a -- There was a neck mass excision which was a very quick surgery, not requiring extensive fluid management or hemotherapy.

Q So you're interpreting her reference to clinical judgment being unsatisfactory as referring to the infant patient, not the 6-year old patient; is that right?

A I'm interpreting they're for both, but there was nothing that she pointed out in the first case that made me think she was referring to my performance in the first case.

She didn't point out anything. She didn't tell me any negative or positive comments during our time together then afterwards; and even when I first saw this, she never commented on them.

Q Okay. Let's look at her handwritten comments at the bottom of this evaluation. Please review everything under pediatric. Is that indicating she thought you didn't deal well with pediatric patients?

MS. SIEGEL: Objection: Calls for speculation.

A I'm not sure what she meant by that. As I

Page 118

1 said, she didn't discuss this with me.

2 MR. LAND: Q Then it reads: It does not
3 matter if you are planning to intubate...general is
4 always your back-up plan. You need to know the way to
5 figure out ETT size and depth; right?

6 A Yes.

7 Q So she is criticizing you for not knowing
8 the ETT size and depth; is that fair?

9 A That's what she seems to indicate there.

10 Q And you didn't address the ETT size or
11 depth in your rebuttal, right?

12 A No.

13 Q Why is that?

14 A From my first statement here, I'm
15 referring to the first case since that's the case that
16 I was involved in mostly. I had covered that I
17 carefully prepared for it and had no difficulties.

18 Q So you just disagreed with her?

19 A She didn't really point out exactly --

20 Q Well, this is pointing out there is a
21 problem with ETT size and depth, and I'm asking you
22 why you are not addressing that; and you said you
23 prepared properly.

24 A It's because I remember my preparation as

Page 119

1 following the reference that's tailored to this
2 particular patient, so I know that I made a correct
3 preparation. But she presented it as if none of my
4 preparation was valid.

5 Q It says: Work on mask ventilation and
6 inhaled induction; right?

7 A Yes.

8 Q Do you address that in your response?

9 A I don't think I did.

10 Q Why not?

11 A Probably because I don't recall exactly
12 what she meant since she didn't really give me
13 feedback, and so I don't recall exactly what I needed
14 to correct or she was referring to.

15 Q Is this evaluation feedback to you?

16 A Yes.

17 Q And you did receive this evaluation around
18 this time; right? You received it in June of 2013?

19 A Yes. But trying to recollect what she
20 meant here, it's hard for me to refute something that
21 I don't recall.

22 Q At the time though you did understand what
23 happened; right?

24 A At the time of the procedure?

Page 120

1 Q Yeah. At the time of receiving the
2 evaluation.

3 A Yes. But if I don't recall what she meant
4 by this when we didn't discuss it --

5 MR. LAND: The witness is pointing to a portion
6 of the document. Can we have the record reflect what
7 she is pointing to.

8 A Work on mask ventilation and inhaled
9 induction, I don't recall what she was referring to
10 there for me to be able to refute that.

11 MR. LAND: Q It indicate: Please draw up
12 medications in the appropriate dose for the child's
13 weight. It would be much easier for you. Do you see
14 that?

15 A Yes.

16 Q Did you address that in your response, in
17 the interrogatory?

18 A I don't think I did that either, and I'm
19 not sure if she is referring to the second case or the
20 first case; but I know that I prepared for the first
21 case as I've indicated here.

22 Q Do you know if you drew up medications in
23 the appropriate dose for the child's weight in the
24 first case?

Page 121

1 A I remember doing that based on my
2 knowledge of the patient's height and weight and
3 what's appropriate for this particular age group.

4 Q Did you draw up medications for the second
5 child?

6 A No. I didn't.

7 Q Did you do anything with respect to the
8 second child except watch?

9 A I just watched.

10 Q Are you sure?

11 A Well, transfer the patient in terms of --
12 Yes.

13 Q You just transferred the patient?

14 A Yes.

15 Q So other than that, you didn't do any work
16 at all on the second patient?

17 A Probably running errands, like if they
18 needed to reach for something, but not directly
19 involved with providing anesthesia for that second
20 patient.

21 Q Were you supposed to be evaluating
22 adjusted changes in the patient?

23 A Not necessarily considering that this is a
24 complicated case like they basically -- Her and the

Page 122

1 anesthesiologist were mainly the ones managing this
2 patient.

3 Q So why were you there then for the second
4 patient?

5 A Because this is an experience that I'm
6 asked to observe.

7 Q How do you know that? How did you know
8 when you had a case where you are just supposed to
9 observe versus actually engage in some anesthesia
10 care-giving role?

11 A Well, they gesture to you to stay on the
12 side; or if they actively perform the procedures, then
13 I don't try to --

14 This is like the first few weeks since
15 my return, and this is pediatrics which we're not
16 exposed most of the time. And they are aware of that,
17 that pediatrics is rare, and this is a more
18 complicated case of a premature baby with a
19 complicated condition.

20 Q Do you remember? Did someone wave at you
21 or tell you somehow not to the engage in any
22 care-giving role here and just observe?

23 A Their actions were indicating that they
24 are going to be managing the patient more.

Page 123

1 Q Whose actions?

2 A Eva Fisher and Dr. Manahas (phonetic). He
3 actually stayed there the whole time for the
4 procedure.

5 Q Your interrogatory response indicates that
6 you didn't see this evaluation from Miss Fisher until
7 June 22nd which was after something we will look at in
8 a minute, an evaluation you got from Jill Wimberly;
9 right? That's your interrogatory response?

10 A Yes.

11 Q And I believe you've alleged that you
12 believe that Miss Fisher created this evaluation after
13 June 20 but backdated it; is that right?

14 A Yes. Well, I didn't hand her this
15 evaluation. She filled it out herself. So the event
16 happened on the 11th, and I guess they she filled it
17 out at some point later.

18 Q Well, she writes the date when she signed
19 it; right?

20 A Yes.

21 Q June 18, 2013. And I believe you are
22 alleging that she falsely listed that date, and she
23 wrote that date on there after June 20th; is that
24 right?

Page 124

1 A I didn't see when she wrote this or what
2 her motives are for writing it that date, so I can't
3 guess her motives.

4 Q I'm not asking about you guessing her
5 motives. I'm saying are you alleging that this
6 June 18th date here is not accurate as to when she
7 filled out this form?

8 MS. SIEGEL: Could I have the question back,
9 please?

10 MR. LAND: I think she understands the
11 question.

12 MS. SIEGEL: I'm sorry. I lost it.

13 MR. LAND: I'll restate it.

14 Q Are you alleging that the June 18th date
15 written here by Eva Fisher was not the date that she
16 filled out and signed this form?

17 A Yes. I believe she backdated this.

18 Q What is the basis for your belief that she
19 backdated this?

20 A Just the encounter of her talking to Jill
21 in the lounge and then subsequently seeing this when I
22 met with Dr. Kremer, not being aware of it prior.
23 Like she had no -- We had no interaction about this
24 date; and then suddenly like closer to, you know, the

Page 125

1 time that I saw them in the lounge, then this
2 reappeared in Dr. Kremer's office.

3 Q In your interrogatory response you
4 indicate that you received this on approximately
5 June 22nd; right?

6 A Yes.

7 Q Is that the only basis for your belief
8 that that's backdated, the date that you got it?

9 MS. SIEGEL: It's been asked and answered.

10 MR. LAND: Actually I haven't asked her about
11 the day she got it.

12 A Yes.

13 MR. LAND: That's the only reason; right?

14 MS. SIEGEL: You didn't ask her about the
15 reason.

16 MR. LAND: Q Let's go back to the summative
17 evaluation if we could. On the first page is a
18 reference at the bottom, bullet point June 20, 2013.

19 A Yes.

20 Q And then that goes on, and on the next
21 page it indicates it was an evaluation from Jill
22 Wimberly?

23 A Yes.

24 Q Let's find that evaluation which is at

Page 126

1 Rush 20. If you look in your interrogatory responses
2 which is Exhibit 3, I believe your response to this
3 evaluation starts at Page 22; is that right? Your
4 response starts at Page 22?

5 A Yes.

6 Q So my first question is: In your response
7 you indicate, This evaluation is flagrantly false and
8 should not be considered. And I want to know do you
9 have any basis for believing that people involved in
10 the SRNA program evaluation can just ignore an
11 evaluation from a CRNA?

12 A If it's full of misrepresentations and
13 there is a lot of falsehoods in it, then I don't think
14 it should be considered valid.

15 Q Do you know of any instance when a CRNA
16 evaluation has just been deleted or not considered at
17 all?

18 A Yes.

19 Q What do you know about that?

20 A Mr. Hakeem Ellis pointed out to Dr. Kremer
21 at one point that there were misrepresentations of his
22 work, and Dr. Kremer -- No. Let me go back.
23 Mr. Ellis said, I've been doing well; and if this
24 jeopardizes my graduation, I will report you to my

Page 127

1 superior for which Dr. Kremer responded, Oh you have
2 enough positive evaluations, don't worry about this.

3 So he made that disappear, but
4 Mr. Ellis kept a copy of it. So he had his full,
5 complete records of his evaluations.

6 Q How do you know Kremer made that
7 evaluation disappear?

8 A Because he didn't give it to Hakeem, but
9 Hakeem had already made a copy of it.

10 At the end of the term, sometimes we
11 request our full records of the different, of our
12 complete evaluations.

13 So Mr. Hakeem didn't receive that one
14 negative evaluation; and Dr. Kremer assured him,
15 That's okay. You have enough positives.

16 Q So do you know one way or the other if
17 Mr. Ellis's file contains that negative evaluation?

18 A Say that again.

19 Q Do you know if that negative evaluation is
20 in Mr. Ellis's file?

21 A No.

22 Q At the top of the evaluation itself --
23 First of all, this evaluation contains many
24 unsatisfactory ratings; right?

Page 128

1 A Yes.

2 Q And you believe that this evaluation is
3 false and fabricated --

4 A Yes.

5 Q -- and unfair; right?

6 Is there anything about this evaluation
7 you think is accurate, the first page?

8 A Well, there are certain, you know,
9 categories here which you can't really miss doing
10 that. Like the labeling syringes, taping eyes. So
11 even though it's just barely satisfactory, I feel at
12 least she gave me a passing grade there.

13 I've always been aware of universal
14 precautions, so the satisfactory ratings on those
15 things I believe I performed well but should be rated
16 a bit higher. So everything that I had performed
17 according to standards was barely rated satisfactory.

18 Q So you find every unsatisfactory
19 evaluative issue here to be -- you take issue with it
20 or you think they're all fabricated?

21 A Pretty much all of it, and I address most
22 of it in my rebuttal.

23 Q What about the reference to incorrect
24 ETT --

Page 129

1 What's the next word?

2 A Drugs.

3 Q -- drugs, do you address that in your
4 rebuttal?

5 A So on the second paragraph of Page 23 in
6 the top I mention: The next morning I went to the
7 hospital early to set up about two hours before the
8 scheduled procedure. Miss Wimberly examined my
9 pediatric case setup and said it was fine. My patient
10 care and preparation document was there as well, and I
11 also informed her I had prepared for two other cases.

12 Q So you are reading about your preparation,
13 not whether you actually used the right ETT and drugs
14 or not; right?

15 A That's what I prepared, basically the
16 airways, the drugs that were going to be used for the
17 case coming up.

18 So she didn't comment on anything wrong
19 or particularly what was wrong with the ETT tube size
20 or what drugs I didn't prepare properly in her comment
21 here. She just made a blanket statement that
22 everything was incorrect.

23 But from my recollection of that day, I
24 set up appropriately based on my tailor-made prep for

Page 130

1 this particular patient. There were I think three
2 cases this day. This is the first one.

3 Q Three cases with --

4 A Three cases.

5 Q -- Miss Wimberly?

6 A For that room with Miss Wimberly, but I
7 only assisted with one of them.

8 Q What about under clinical judgment, F,
9 develops a postoperative plan of care where she
10 wrote -- I think it says incorrect dosing for postop
11 pain management, does not know correct dosing for
12 opioids?

13 A Yes.

14 Q Do you address that in your response?

15 A Yes. So on Page 23, the paragraph that
16 starts with Miss Wimberly's account of the dosing is
17 false both in terms of what was actually said and of
18 the substance of the medical information. For
19 example, Miss Wimberly did not ask about the use of
20 Tylenol. Miss Wimberly was herself incorrect about
21 the use of morphine. I meant the dosing of the
22 morphine she suggested.

23 Similarly, her statements are erroneous
24 regarding Fentanyl dosing. Specific and standard

Page 131

1 dosing quantities for Fentanyl dosing were not
2 recommended anywhere in the postop pain
3 management, and I was referring to my surgical book
4 for anesthesiologists. I have since specifically
5 researched this point to check for error.

6 So I addressed those things because she
7 elaborated more of it in the narrative she wrote down.

8 Q When it references dosing for opioids, is
9 that the morphine?

10 A Morphine and Fentanyl specifically.

11 Q Both of them are opioids?

12 A Yes.

13 Q Why didn't you address the dosage of
14 morphine in your rebuttal directly?

15 A I mentioned that her suggestion of my
16 answer was incorrect with what the dosing for morphine
17 is. I refuted here that her suggestion was not
18 entirely correct; so my rebuttal here was addressing
19 the morphine use, meaning use and dosing.

20 Q So you had a difference of opinion about
21 that from Miss Wimberly?

22 A It's not my opinion. It's the reference
23 that I was using based on a pediatric emergency drug
24 book.

Page 132

1 Q If you turn to the second page of her
2 evaluation, the handwritten page, I have a few
3 questions. At the top there is a line. It starts on
4 the right upon trying to help encourage her. Do you
5 see that?

6 A Uh-huh, yes.

7 Q Upon trying to help encourage her in the
8 right direction for dosing and figuring out ETT sizes,
9 she continually made excuses -- I think that's says
10 and -- and said things like "on my previous cases" or
11 "I don't have a cheat sheet."

12 So my question is, did you discuss ETT
13 sizes with her?

14 A No, because it was already prepared and
15 she examined it at the beginning of the case; and she
16 had no comment about it.

17 Q So you are saying she was making up she
18 talked to you about ETT sizes and dosing?

19 A She made that up.

20 Q And did you say on my previous cases or I
21 don't have a cheat sheet, did you make any comments
22 like that to her?

23 A I made those comments in terms of how the
24 morphine was dosed from a previous experience that I

Page 133

1 had, and so I was rationalizing with her how I was
2 taught previously to dose morphine based on a recent
3 pediatric case that I had with Miss Eva Fisher
4 actually.

5 So that's when I used that comment, not
6 because of this ETT tube sizing. She had no comment
7 about my prep for ET tube size or drugs at the start
8 of the case.

9 Q So your reference to previous cases had to
10 do with dosing of drugs?

11 A Dosing of the morphine.

12 Q She says here that you said you didn't
13 have a cheat sheet. You had lost your preparation
14 document; right? Had you lost your preparation
15 document?

16 A No. It was taken away by the OR nurse,
17 and then I was able to retrieve one of them. I don't
18 know what happened to the rest.

19 Q Did you have that document during the
20 procedure?

21 A Yes.

22 Q During the case?

23 A Yes.

24 Q You had it there with you?

Page 134

1 A Later on, not immediately. Like I said,
2 the OR nurse took my prep papers along with the
3 patient's medical records. And when I recognized
4 that, I was able to retrieve part of it and came back
5 to running the case again, put it in plain view to her
6 so she knows that I did have a bunch of preparation
7 papers for this particular case.

8 Q So you left the procedure for a little bit
9 and then came back?

10 A No. It's inside a room. It's just that
11 the paper was moved to a different work desk within
12 the OR room.

13 Q So you never told her that you didn't have
14 a cheat sheet?

15 A I told her I don't have my cheat sheet
16 now.

17 Q So you did tell her that?

18 A Yes, but probably in in the middle of the
19 case.

20 Q Did you refer to those preparation
21 documents as a cheat sheet generally?

22 A Well, not all of them. I meant the
23 summary of drugs and particular doses that is specific
24 to this particular patient.

Page 135

1 Q She next writes here: I asked her if she
2 had figured out dosing for patients in the room
3 (induction dosing, emergency drugs, etc. for each
4 patient). She said she had but was unable to provide
5 any evidence that she had done so.

6 So my first question is: Did she ask
7 you if you had figured out dosing for patients in the
8 room of the types listed here?

9 A That's what the CRNAs do with the SRNAs in
10 the morning. They quiz you with the drugs that you
11 have prepared, and I remember that day she had asked
12 me what the dosing was for particular emergency drugs
13 and I think particularly for pediatric patients. So
14 she quizzed me in the morning, and she had seen that
15 the drugs that I've drawn up.

16 In addition, I told her that I spoke to
17 Dr. Meyer because he wanted to do a caudal anesthesia
18 prep which involved a different mixture of drugs, and
19 so I informed her that I did those because she hadn't
20 talked to Dr. Meyers then. And so I just updated her
21 that Dr. Meyers wanted this particular mixture of
22 drugs for the caudal anesthesia that we were planning
23 on performing for this case.

24 Q So you're saying you did have evidence

Page 136

1 that you had figured out the dosage when she asked
2 you?

3 A I had the syringes laid out, so that's my
4 evidence.

5 Q Did you show it to her?

6 A She looked at every one of them.

7 Q She then writes: I then asked how her
8 drugs were dosed, and she lists some references to --
9 I think was that milligrams of kilograms or something,
10 for the drugs, and she was unable to tell me. Did
11 that happen? Did she ask you?

12 A I think she specifically asked about the
13 succinylcholine because I think that's one of the
14 emergency drugs she wanted to know, and I had just
15 answered that question from a previous case. So I
16 told her the answer, and she didn't have --

17 Oh, she also asked about Atropine, what
18 the dosing is for pediatrics, and I told her about
19 that too.

20 Q When she writes doesn't know drug dosing
21 at all, you're saying that is not true because you
22 told her how you dosed the drugs?

23 A I answered all of those questions
24 satisfactorily before the beginning of our case.

Page 137

1 Q How do you know it was satisfactory to
2 her?

3 A Because she nodded, and she didn't counter
4 or she didn't correct me; and I based it on a recent
5 reference that I had just reviewed.

6 Q Then the next line of the text that she
7 wrote says: After some time in the OR, it was time to
8 put in postop orders for the patient. It says she
9 wanted to order for a patient that was 26 kilograms
10 post inguinal hernia repair morphine 4 milligrams.
11 I think that's a reference to what you wanted to
12 order.

13 A She asked me. That's not correct. That's
14 not how it went. So I filled out the first portion of
15 the PACU or the postop orders which did not include
16 drugs. It was mostly like monitor vital signs q such
17 and such for how many hours, where the patient is
18 going to be transferred, so nonmedication portion of
19 the orders.

20 Then the second section is all about
21 medications. And before I was able to input that
22 because it just is by clicking, she first asked me do
23 you know what the dosing is for morphine; and I gave
24 her an answer. And that's when I also justified my

Page 138

1 answers with the suggestions that Miss Eva recommended
2 to me in my previous case with a similar weight and
3 aged patient in pediatrics.

4 And so she asked me these questions.

5 I wasn't inputting it because she decided to take over
6 at that point. When I didn't answer -- I think it's
7 about when she asked me about the Fentanyl. She asked
8 what is Fentanyl dosing for pediatrics; and when I
9 answered, I believe my answer was 1 mic. per kilo
10 based upon the reference I had, she said, That's
11 wrong. Step away. I'll take over now because you're
12 going to overdose the patient. So she didn't lay out
13 these sets of doses here from my recollection.

14 Q Wasn't this saying what you wanted?

15 A No. She asked me what the morphine dosing
16 is.

17 Q You're saying she wanted to order it means
18 you; right?

19 A No.

20 Q That's what it means?

21 A That's what she wrote there, but that's
22 not what I was doing. I was answering her question,
23 and I wasn't putting the orders in.

24 Q You were or were not?

Page 140

1 portion.

2 Q It later says, We could order --

3 MS. SIEGEL: She's not finished with her
4 answer.

5 (Whereupon the last answer
6 was read.)

7 A Yeah. She didn't really give me a chance
8 to comment or answer her aside from her straight
9 forward questions of do you know the dose of such and
10 such drugs.

11 MR. LAND: Q Okay.

12 A She also did not ask me about the dosing
13 for Tylenol; and when Dr. Kremer and I were going
14 through this, I told her the things that had happened,
15 and he threw the paper and says, Your account is not
16 lining up with hers. So she is saying something
17 differently, and my recollection was different from
18 when he was writing down, you know, when they met with
19 me and he was writing down.

20 Q Were you nervous during this exchange with
21 Jill Wimberly?

22 A Yes.

23 Q Was it stressful?

24 A Because she was screaming at me before

Page 139

1 A I was not in terms of the drug section of
2 the order sheet.

3 Q She was asking you about dosing --

4 A Yes.

5 Q -- and disagreeing with your answers;
6 right?

7 A Yes.

8 Q And you were referencing your previous
9 experience in answering those questions; right?

10 A Plus the reference material that I had
11 there based on a pediatric activity worksheet that I
12 researched beforehand.

13 Q Can you go down a little further in that
14 same section. It says: I then explained that this
15 child would not need much pain medicine postop. Do
16 you see that?

17 MS. SIEGEL: I'm sorry. Where are you reading?

18 MR. LAND: It's down a few lines in the same
19 paragraph. It starts on the far right.

20 Q I then explained that this child would not
21 need much pain medicine. Did she explain that to you?

22 A I think she mentioned that, and so we were
23 thinking about including Tylenol; but she didn't
24 really go at length. She was very curt in that

Page 141

1 this case started, and it reminded me of the event the
2 previous night where she just harassed and verbally
3 abused Karen in front of the other surgical team and
4 in front of Kim Huntzinger. That's why Kim Huntzinger
5 apologized for how she was treated the day before.

6 Q Do you think your stress and nervousness
7 affected your ability to take in information and to
8 remember during the case?

9 A No, because after I was dismissed from
10 this case, I recalled the event with my classmate
11 Ebele because she knew about the event too that
12 happened with Karen; and I went through all of the,
13 you know, events that transpired that day.

14 So I had told her. Then I had told
15 Karen Cam afterwards. So several repetitions made me
16 remember the exact events of what happened.

17 Q So you believe you were taking in and
18 observing everything that was happening just fine
19 during this case?

20 A Well, I was remembering exactly what her
21 questions were because I also looked back on my
22 reference.

23 In addition, when Dr. Kremer and
24 Dr. Wiley were examining or discussing this with me, I

Page 142

1 told them that it's really difficult to find specific,
2 you know, particularly Fentanyl and morphine from the
3 references we have. The pediatric workbook or
4 textbook didn't have it. The surgical anesthesia
5 textbook didn't have it, and they both pulled it from
6 their shelf and they didn't find it.

7 So Dr. Wiley suggested to me, Why don't
8 you look for a pediatric anesthesiologist and ask them
9 or him if your recommended suggestion was or what you
10 suggested was appropriate.

11 And so that's when I looked up Dr. Tim
12 Shively who was still a staff there up until July. So
13 it's false that they said here he wasn't.

14 Q I'm sorry. I don't mean to interrupt
15 except that we have some time complaints on how long
16 we can do this, and the question I asked is different
17 than what you are answering and I believe you are
18 trying to answer.

19 But what I asked was whether your
20 stress and level of nervousness impacted your ability
21 to take in information during this case?

22 A I don't think so. I felt like I was
23 thinking clearly and remembering, you know, the
24 crucial events of that day so I could basically vouch

Page 143

1 for myself when the time comes that this has to be
2 recalled.

3 Q So the interactions with Miss Wimberly
4 didn't affect your ability to perform during this
5 case?

6 A I felt -- Well, it did in some sense.
7 I felt like after Miss Wimberly, like after she had
8 stepped me aside, I was shaken a little bit just
9 feeling embarrassed and humiliated in front of the
10 surgical team. Yeah. The surgical team was stopping
11 and looking at us because she was screaming at me.

12 Q But you don't think that that distracted
13 you from being able to take in information and
14 remember it and process it, that level of
15 embarrassment?

16 A Well, I know what was correct and what I
17 needed to know at that time; so I probably don't
18 remember the other details. But the ones that I felt
19 were important that I discussed several times with
20 Dr. Wiley and Kremer, I have it in good recall.

21 Q Later in this handwriting it talks about:
22 I again had to reiterate the type of procedure and
23 pain management needs expected as well as appropriate
24 drug dosing for this patient. Did she have to do that

Page 144

1 for you?

2 A No.

3 Q Did she do that?

4 A No.

5 Q So she didn't repeat anything about the
6 type of procedure or pain management needs?

7 A No. She just says, You will overdose this
8 patient, step aside. I'm taking over, and she stopped
9 talking to me for the most part.

10 Q In the next what looks like paragraph of
11 this handwriting, it starts: After several unsafe
12 practices in the OR, incorrect repeated dosing, and
13 incorrect airway management, did you have any issues
14 with airway management? I'm not asking you if you
15 agree with the characterizations here. I'm just
16 asking you did you have any issues with airway
17 management in this case?

18 A From what I recall, I intubated the
19 patient without any issue. I believe I got it in one
20 shot.

21 Q Are you sure?

22 A From what I recall, I was the one who
23 intubated the patient.

24 Q Was that the only airway management that

Page 145

1 needed to be the done, intubating the patient?

2 A Well, of course managing the anesthesia
3 machine which she didn't really comment on like
4 specifically. So, yes, I'm sure.

5 Q Can you turn to the next page of this
6 evaluation. This handwriting indicates: When
7 redirected or corrected, Maricel continually makes
8 excuses about her performance. Do you see that?

9 A Yes.

10 Q Did you receive redirection or correction
11 from Miss Wimberly?

12 A Not that I recall.

13 Q So she might have tried to redirect you or
14 correct you?

15 A No. She just said I was wrong when I gave
16 her an answer to the drugs.

17 Q Well, you talked about a lot of other
18 things than just the drugs; right?

19 A Yes.

20 Q She says you continually made up excuses
21 about your performance. Did you try to explain why
22 you had done what did you?

23 A I think the only excuse I made was when I
24 referred to Eva Fisher suggesting in terms of the

<p style="text-align: right;">Page 146</p> <p>1 morphine dosing. That's in reference to on my 2 previous case where I was referring to Eva's 3 suggestion on morphine dosing. And that's the only 4 excuse or the only explanation that I tried to tell 5 her. 6 Q The last sentence of what she writes here 7 is: She brushes off learning experiences or 8 instruction if different from her previous thoughts of 9 how day should go. I couldn't know what that says, 10 she? 11 A Should do LMA. 12 Q If thinks should do LMA but do ETT 13 instead, unable to be redirected. Do you see that? 14 A Yes. 15 Q Did that happen in this case? 16 A No. This was general surgery. So for 17 pediatrics we didn't have to use LMAs which is usually 18 for not as severe as this or not as involved as the 19 surgery from my recollection. 20 So I don't recall that we discussed 21 LMAs or that it was even something that was going to 22 be used in that particular surgery. 23 Q So you don't think that was in your 24 preparation --</p>	<p style="text-align: right;">Page 148</p> <p>1 A Yes. 2 Q So I also don't think you referenced the 3 LMA question at all in here. That's listed in the 4 evaluation here in your rebuttal; right? 5 A No. 6 Q Let's go back to the summative evaluation, 7 the front page of Exhibit 4. The next bullet is 8 July 1st, 2013. It's listed as an unsatisfactory 9 rating from Alida Hooker. Do you see that reference? 10 A Yes. 11 Q And you can find that evaluation at Rush 12 24. 13 A Okay. 14 Q Then if you turn to Page 21 of your 15 interrogatory responses is your explanation or 16 addressing that unsatisfactory rating from Miss 17 Hooker? 18 A Rush 21? 19 Q If you stay on Rush 24, and it's Page 21 20 of the interrogatory responses. 21 MS. SIEGEL: Did you say Page 21? 22 MR. LAND: Yes, 21 of the interrogatory 23 responses. 24 Q If you look at the evaluation first, this</p>
<p style="text-align: right;">Page 147</p> <p>1 A No. 2 Q -- the idea of an LMA but then ended up 3 doing an ETT instead? 4 A I don't recall preparing an LMA, just 5 different ET tube sizes. 6 Q Is it possible that that was the 7 preparation, the preparation was for LMA and it 8 switched for an ETT? 9 MS. SIEGEL: Calls for speculation. 10 A I'm trying to recall. That was a major 11 surgery I think. I'm not sure. I know that we ended 12 up using an ET tube, and there were no talks about 13 using an LMA from my recollection in place of an ET 14 tube. 15 And usually with surgeries, LMA would 16 be the first consideration if they think that surgery 17 would just be an LMA and an ET tube would be the 18 backup, not the other way around. So you choose an ET 19 tube and usually stick with it and not go back and do 20 a less invasive airway which is an LMA. 21 MR. LAND: Q We talked about the ETT question 22 before and your rebuttal, and you said that I think 23 the place you referenced anything relating to ETT was 24 in your preparation paragraph; right?</p>	<p style="text-align: right;">Page 149</p> <p>1 is from Alida Hooker on I can't tell if it's July 1st 2 of 2013 or July 2nd. I think it's July 1st, and the 3 evaluation was written on the 2nd. 4 But you see this evaluation and there 5 is one unsatisfactory rating; right? 6 A Yes. 7 Q And that's for recognizes intraoperative 8 complications? 9 A Yes. 10 Q In your response, in your interrogatory 11 response you indicate in that first paragraph a 12 response to the assertion that you had compromised 13 patient safety through inadequate blood pressure 14 management. You say this is false. Do you see that? 15 A Yes. 16 Q Then you say the patient had a normal 17 blood pressure, and on one reading there was a 18 20 percent drop? 19 A Yes. 20 Q And the CRNA faulted me for not taking 21 immediate action? 22 A Yes. 23 Q So that happened; right? There was a 24 20 percent drop?</p>

Page 150

1 A Yes.

2 Q And she thought you should have reacted
3 quicker?

4 A Her opinion was that I should treat that
5 one data point and, yeah, just react to that one
6 particular event.

7 Q Okay. And you disagreed with that?

8 A I disagreed that I needed to address that
9 versus basically trending the vital signs to see if it
10 actually improved on its own instead of us
11 overshooting one particular abnormal blood pressure
12 reading basically.

13 Q How unusual is it for there to be a
14 20 percent drop in blood pressure?

15 A It's common because we're providing
16 anesthesia, and the gases can cause intravascular
17 instabilities, hemodynamic instabilities.

18 Q On the second page of the evaluation
19 itself --

20 A Yes.

21 Q -- in the handwriting there is a reference
22 that you had discussed I think it's GlideScope --

23 A GlideScope.

24 Q -- for preop for airway. Is that reasons?

Page 151

1 A Where are you?

2 Focus on getting the GlideScope ready
3 and in place. I think it got cut off, and in place.

4 Q You don't place the DL blade and handle
5 under the patient's pillow for intubation.

6 So I didn't see any reference I don't
7 think in your response to that question?

8 A In terms of arguing against it, I mean
9 that's her suggestion; and it's something that she
10 prefers, but other anesthesiologists or practitioners
11 would not take issue with. So I didn't think it was
12 something I needed to respond to.

13 Q So this actually happened?

14 A I believe so, to my recollection.

15 Q And she had addressed that with you during
16 the procedure?

17 A Just briefly I think. No. She didn't
18 tell me about not putting the DL blade under the
19 patient's pillow. It's just something she observed
20 and then wrote later her observation.

21 Q In the handwriting it looks like two
22 paragraphs lower it says: Be proactive with treating
23 the vitals and making vent changes. Not only write
24 down/chart the information but know what is safe for

Page 152

1 the patient. And then it looks like SBP.

2 A Systolic blood pressure within 20 percent
3 of baseline lane or unrelaxed patient.

4 Q And be proactive with treating the patient
5 and making changes?

6 A Yes.

7 Q That's a reference to the same 20 percent
8 drop we talked about before?

9 A Yes.

10 Q And you disagreed with her criticism of
11 you?

12 A I didn't disagree with her opinion because
13 that's her preference, but I disagreed that's the only
14 way of managing that change in vital sign because as I
15 refuted here, I was trending which means I take it
16 several data points and act on the average of that
17 which actually takes -- I'm not sure. I think this
18 patient might have had an art line. I'm not sure.
19 But within a 10-minute period, you've had three vital
20 signs then.

21 So if the patient improved in the next
22 ones, then for me there is no need to correct it
23 because she could overshoot it and actually make the
24 patient hypertensive.

Page 153

1 Q Did you perceive this evaluation from CRNA
2 Hooker as discriminatory in any way or biased against
3 you?

4 A Yes.

5 Q Why?

6 A Because it's misrepresenting my actions or
7 my opinions of what her, in her rating here with
8 making me unsatisfactory when she didn't really ask me
9 my reasoning. She just assumed that I wasn't going to
10 address this problem.

11 Q You said it misrepresented your actions,
12 and I'm not sure that that's right?

13 A My actions in terms of not reacting or
14 treating that one data point, not correcting that one
15 data point.

16 Q I think in this evaluation -- I'm not
17 sure, but tell me -- I think you agree that she is
18 recording facts accurately, and the judgment she has
19 about whether they should have happened that way
20 differ from you; is that fair?

21 A No.

22 Q No?

23 A No, because I've observed --

24 Q Like the 20 percent blood pressure change

Page 154

1 happened; right?

2 A It did.

3 Q Okay. And the GlideScope discussion here
4 addresses things that happened; right?

5 A Yes.

6 Q Okay. And the reason you think that this
7 is discriminating and biased against you is because
8 you disagree with the judgments she made about whether
9 those are accurate steps to take or proper steps to
10 take?

11 A No. She didn't ask me my line of thinking
12 which was also valid; and so she made a judgment
13 without asking me why did you not treat it, that one
14 point.

15 Q Why did you think that was motivated by
16 bias against you because of race or national origin?

17 A I'm just not sure how it is that she was
18 rash in judging me here whereas the previous time she
19 wasn't, and this had occurred shortly after my
20 encounters with Jill and Eva.

21 Q Do you have any indication or any basis to
22 believe that CRNA Hooker was communicating with Jill
23 Wimberly or Eva Fisher in any way to collude against
24 you?

Page 155

1 A From what I'm hearing, they have weekly or
2 some CRNA meetings; and there is potentially an
3 opportunity there that Miss Hooker might have been
4 influenced by Miss Wimberly or Miss Eva.

5 Q You are saying that would be improper if
6 weekly or monthly meetings involved some communication
7 between CRNAs and it influenced their view of how to
8 evaluate students?

9 A If it's an improper influencing of that
10 CRNA, yes, I think it's not appropriate that they
11 should be sort of coloring their impression of a
12 student.

13 Q So doing that at all would be a problem?

14 A If they are being biased, the coloring is
15 in making a false impression of a student and sharing
16 that impression to the CRNA or another CRNA.

17 Q How long had CRNA Hooker been a CRNA?

18 A I don't know.

19 Q What you're saying I think is that if she
20 heard some negative comment from Jill Wimberly, she
21 wouldn't evaluate you based on her own judgments?

22 MS. SIEGEL: Mischaracterizes.

23 MR. LAND: Q Is that what you're saying?

24 A What I'm saying is there is a known or

Page 156

1 there is, the students have recognized that there have
2 been talks about CRNAs talking to each other about how
3 they're going to treat certain students.

4 Q But you don't know if Miss Hooker had any
5 such communication with anyone about you; right?

6 A No.

7 Q And you are saying you think this is
8 biased against you which suggests you think she is not
9 employing her own judgment about whether these were
10 problems. Is that what you're saying?

11 A I'm saying she made that judgment without
12 full understanding of what my reasoning is of not
13 reacting directly to that particular problem she was
14 pointing at.

15 MR. LAND: Let's take a break.

16 (Whereupon a brief recess was had,
17 after which the deposition of
18 Ms. Marcial continued as
19 follows:)

20 Q Maricel, could you turn in Exhibit 4, the
21 one you are looking at, Rush 26 at the bottom. Turn
22 to that page.

23 A Yes.

24 Q So Rush 26 is an email from Alida Hooker

Page 157

1 to Mike Kremer dated July 2nd, 2013, and it's
2 addressing I believe the patient care situation that
3 was part of CRNA Hooker's evaluation that we were just
4 talking about?

5 A Yes.

6 Q That's what this looks to you to be
7 talking about?

8 A Yes.

9 Q It starts in the first couple of
10 sentences, it talks about how you were really
11 prepared, had event, a cart, a drug tray with
12 induction drugs all set up, that you had taken efforts
13 to get other aspects of preparation set up; and it's
14 praising you there; right?

15 A Yes.

16 Q Then it goes on to explain that you
17 appeared disorganized when you got to intubation?

18 A Yes.

19 Q Do you have any reason to think that Alida
20 Hooker didn't believe that, that you appeared
21 organized to her or disorganized to her?

22 A From my recollection, she was commenting
23 on this because I initially had reached for direct
24 laryngoscopy as sort of a force of habit because

Page 158

1 normally what's what we use, and I stopped myself from
2 doing that and redirected myself to doing the
3 GlideScope instead.

4 That's the only aspect I think that she
5 is commenting on of me being disorganized, just
6 because I veered briefly and then went back to the
7 original plan of using GlideScope.

8 Q You are saying you didn't actually grab
9 the DL blade and handle?

10 A No. I didn't because it's in a different
11 section. The GlideScope is right next here, so I
12 might have reached this way for the DL; and for her,
13 that was an irregularity that even though I --

14 You know what, I think I might have
15 grabbed it and then -- Let me just because my
16 recollection is a little fuzzy. I might have grabbed
17 it initially but then realized that we were doing
18 GlideScope, and that's why I had set it down and
19 instead redirected on using the GlideScope.

20 Q She writes after reference to the DL blade
21 and handle that she asked -- It says, I asked her how
22 she wanted to intubate the patient, giving her the
23 choice and letting her think through it. Did that
24 happen? Did she ask you that question? Do you know?

Page 159

1 A I don't recall, but she might have.

2 Q Down a couple of paragraphs there is a
3 reference to after we discussed 20 percent of baseline
4 and identifying a number, she stuck with it?

5 A Uh-uh, yes.

6 Q Is that a reference to the blood pressure
7 question that we talked about before?

8 A Yes.

9 Q And did you change what you were doing
10 after she brought that 20 percent of baseline idea up?
11 She says you stuck with it.

12 A Yeah. So basically what I think she meant
13 is that I made sure that the blood pressure was above
14 the baseline, 20 percent above baseline.

15 Q So you did change what you were doing
16 after that?

17 A There was not a change as so much a
18 reacting to drops in blood pressure, so I did -- Well,
19 I did change my perception of, you know, treating
20 blood pressures.

21 Q The next sentence says: With the
22 anesthesia she made poor judgment calls of lowering
23 the CVO and not having muscle relaxant on board for
24 this prone case with a delicate surgery. Did that

Page 160

1 happen? Did you lower the CVO?

2 A I don't recall that part, but what I'm
3 confused about is not having muscle relaxant on board
4 for this prone case with a delicate surgery because as
5 I did a rebuttal here, you give muscle relaxant before
6 you intubate somebody, and there is a leftover. There
7 is leftovers there. And throughout the case we check
8 twitches to see if they're returning with their motor
9 movements and re-dose accordingly.

10 So I don't think that I would agree
11 with this portion here, not having muscle relaxant on
12 board.

13 Q You started by saying that you don't
14 recall; right?

15 A I don't recall the CVO part, but the
16 muscle relaxant -- Well, I'm just rationalizing
17 because I don't recall what specific muscle relaxant;
18 but it's not possible to not have a muscle relaxant on
19 board on a case like this because you can't intubate
20 the patient who would potentially move. So that
21 doesn't make sense that I wouldn't have a muscle
22 relaxant on board.

23 Q Isn't that kind of what she is saying is
24 that that was the problem was that you didn't have it

Page 161

1 and should have known to have it?

2 A So then I argue that that's not correct.

3 Q But I think you are saying you don't
4 recall if you had it or not?

5 MS. SIEGEL: Objection: Mischaracterizes her
6 testimony.

7 A I don't recall the dosing or which
8 particular muscle relaxant it is, but I'm not saying
9 that I don't recall having it. I just don't recall
10 the specific drug or muscle relaxant in the dose that
11 we gave.

12 But I recall that there is a muscle
13 relaxant involved; otherwise it would not be possible
14 to perform even the intubation part because that goes
15 hand in hand in any case. That's a general case.

16 MR. LAND: Q Okay. The next couple of
17 sentences down says: Maricel also asks "permission"
18 from me almost every time she did something; i.e.,
19 re-dosing medication, checking twitches. Did you do
20 that a lot?

21 A It's possible, I guess just trying to
22 gauge her preferences since she -- When she called my
23 attention to the 20 percent baseline, I guess I was
24 trying to gauge her style or her way of managing.

Page 162

Page 164

1 Q Later near the end it writes: Overall
 2 Maricel has a great setup; but during the case, she
 3 becomes scattered and acts in a nervous rush. I found
 4 myself double-checking everything she did and
 5 redirecting her on a regular basis.
 6 Do you have any reason to think that
 7 Alida Hooker didn't believe that?
 8 A Believe what exactly?
 9 Q That you became scattered and acted in a
 10 nervous rush and that she felt compelled to
 11 double-check everything you did and redirect you on a
 12 regular basis?
 13 A Yeah. I questioned her statements on
 14 redirecting me on a regular basis because I think from
 15 my recollection she had to go away for a break and she
 16 was relieved by the anesthesiologist.
 17 So at that point most of the time
 18 anesthesiologists aren't very hands on with the
 19 student RNA's. So for that period of time I was
 20 really running the case and didn't require too much
 21 direction from the anesthesia staff there.
 22 So I'm not sure if she is gauging this
 23 based on a couple of things that I didn't do which is
 24 the treating of the blood pressure and also my

1 A To the best of my knowledge, I remember
 2 performing well that day.
 3 Q Did you ever think that Jillian Klunk was
 4 biased against you?
 5 A No. I don't think so.
 6 Q If you turn to Rush 34, this appears to be
 7 an evaluation of you by Judy Wiley --
 8 A Yes.
 9 Q -- from a clinical case from July 23rd,
 10 2013; is that right?
 11 A Yes.
 12 Q If you turn to your interrogatory
 13 responses at Page 20, I believe you respond there to
 14 this evaluation and what's enumerated in Paragraph 2;
 15 right?
 16 A Yes.
 17 Q If you look back at the evaluation itself,
 18 under patient safety, paragraph C, it says below level
 19 expected?
 20 A Yes.
 21 Q I needed to point out airway obstruction
 22 on one occasion, but after that Maricel recognized it
 23 without prompting.
 24 A Yes.

Page 163

Page 165

1 inadvertent taking of the laryngoscope, the DL instead
 2 of the GuideScope that we agreed on. So that's why I
 3 don't know exactly which one she was referring to as
 4 far as constantly redirecting when she was gone for
 5 part of the case.
 6 Q She wrote this the day after this
 7 happened; right?
 8 A It appears like it.
 9 Q Had she talked to you about the case at
 10 all at the time?
 11 A No.
 12 Q Could you turn to page Rush 29?
 13 A Okay.
 14 Q This looks like an evaluation from Jillian
 15 Klunk dated July 9th, 2013 of you --
 16 A Yes.
 17 Q -- which is positive and rates you as
 18 satisfactory or outstanding in every category; right?
 19 A Yes.
 20 Q It says: Great job today, well-prepared,
 21 knowledgeable about the case; right?
 22 A Yes.
 23 Q And so do you believe this is fair and
 24 accurate assessment of your performance that day?

1 Q Did that happen?
 2 A I recall it did probably once; and I might
 3 have like turned to get something. It's possible,
 4 yeah. I think it did happen.
 5 Q I ask because that's not addressed in your
 6 interrogatory response. I didn't see it.
 7 A Yeah. I believe there was one instance
 8 when the patient was I guess snoring louder, and
 9 that's an indication of some form of airway
 10 obstruction that she pointed out and I corrected or I
 11 acted on.
 12 Q In psychomotor skills in the evaluation,
 13 paragraph B rates you as below level expected. It
 14 indicates: ETT placed in first attempt, had to remind
 15 Maricel twice that we do not ventilate with RSI.
 16 Maricel asked about placing OGT and esophageal
 17 temperature probe on our general case. Patient with
 18 foreign body in stomach and esophagus.
 19 And I think you took issue with her
 20 saying that she had to remind you twice not to
 21 ventilate with the RSI in your interrogatory response.
 22 But I think your interrogatory indicates that she did
 23 tell you not to ventilate with RSI; is that right?
 24 A Yes. I argued that she mentioned here I

Page 166

1 did it twice; but from what I recall, I actually just
2 did it once and did not do it again.

3 Q If you look at additional comments on the
4 second page of the evaluation, a couple sentences in,
5 it says: Could not discuss importance of checking for
6 return of twitches after using -- I'm not going to try
7 to pronounce that -- a drug for administering a
8 nondepolarizing muscle relaxant.

9 What happened there. Do you remember
10 that?

11 A So she was asking me what that syndrome
12 was that prevents or delays a patient's recovery from
13 succinylcholine which is a paralytic. So she did not
14 ask me to discuss it. She asked me about the syndrome
15 which I had forgotten then.

16 And I researched it later. What she
17 was meaning was pseudocholinesterase syndrome. So she
18 had asked me what it was, not that she wanted me to
19 discuss it. So I think her recall of it is not the
20 same as what we really happened.

21 Q So she asked you about it and you didn't
22 know, and you went and looked it up. Is that what you
23 said?

24 A Yes.

Page 167

1 Q Did you find this evaluation, did you
2 think this evaluation was fair?

3 A No.

4 Q Why not?

5 A I believe some of them were not accurate
6 in terms of the twice that she had prompted me to not
7 ventilate in RSI. As I rebutted here, I was only
8 instructed once; and I didn't do it again.

9 And in terms of how she phrased this
10 syndrome which I didn't know then, she didn't ask me
11 to discuss it. She just asked what it was, but she
12 presented it differently. So that wasn't accurate.

13 Q How is it different to say could not
14 discuss and you are saying she asked you and you
15 didn't know the answer? How are those not consistent?

16 A Because she was referring here, Why is it
17 important? What's the importance of checking for
18 return of twitches which what I remember her asking is
19 what syndrome is it called when that we need to be
20 recognizing the importance of return of twitches with
21 the use of succinylcholine.

22 From what I recall, I know the
23 significance of checking for twitches with any muscle
24 relaxant; but it's misrepresented here that I did not

Page 168

1 know the importance of checking for those vital signs
2 to be returning when using a paralytic.

3 So it undermines my ability to
4 recognize -- correcting any complications or
5 anticipating any complications. So the way this is
6 worded is making it look like I had no clue of my role
7 in using these drugs and the possible complications
8 associated with it.

9 Q The next sentence on that narrative says:
10 This material was covered during fall semester 2012,
11 almost a year ago. Is that accurate?

12 A As far as I know, yes. That's like the
13 didactic period.

14 Q If you turn to page Rush 38, this appears
15 to it be an evaluation prepared by Amy Gawura; is that
16 right?

17 A Yes.

18 Q It's dated July 30, 2013?

19 A Yes.

20 Q It rates you as an unsatisfactory with
21 zeros in several categories; right?

22 A Yes.

23 Q Before this date of being evaluated by Amy
24 Gawura, did you think she was fair, thorough, and

Page 169

1 tough?

2 A I thought she was fair. I mean she was
3 tough, but myself and the other students had
4 reservations about how she was treating us because we
5 felt she was a little abrasive sometimes. And so we
6 were not sure if our skills are being graded, you
7 know, accordingly. Like we felt that she could really
8 give us a lower grade than our actual performance.

9 Q When you say she was abrasive, then you
10 talked about how she was a tough grader or graded
11 lower than you thought she should, is there some other
12 way she was abrasive besides grading?

13 A Just with her interaction. Like sometimes
14 she doesn't care for like explanations, like I don't
15 care. Just sometimes we'd get cutoff when we're
16 explaining things, just the general interaction.

17 And also her having warned another
18 student, that if he complained about not getting the
19 cases he wanted, that you might get punished or you
20 might get given a heavier load which will make you
21 like work longer hours.

22 Q Who is that student?

23 A I don't recall. I just -- Yeah. I don't
24 recall who it was.

Page 170

1 Q Do you recall anything about the other
2 student who said that?

3 A I think it was a guy because I think I
4 shared a case with him, but there is like -- I think
5 we only have one minority, and then the rest are white
6 guys. So it's hard to determine if it's Horey or Nate
7 or Ed.

8 Q So it could have been a white guy?

9 A Yes.

10 Q Before July 30, 2013, had you ever
11 received a negative evaluation from CRNA Gawura?

12 A I don't think so.

13 Q If you could turn to the next page in that
14 exhibit --

15 A Yes.

16 Q -- it's a two-page written summary from
17 Amy Gawura about that day. It starts by saying it was
18 a challenging day for you. It's saying you had
19 difficulty applying many concepts that had been
20 discussed in basics of anesthesia course last fall.
21 And it says: During our second case, she had trouble
22 placing and managing an LMA in a healthy 18-year old
23 female.

24 Is that true?

Page 171

1 A Also that it look longer than usual.

2 Q And it says: After induction, she
3 attempted had to ventilate the patient twice, first
4 with an oral airway and then with just a mask. I had
5 to instruct her that LMAs are immediately placed after
6 loss of a lid reflex and no masking is necessary. Did
7 that happen?

8 A It's possible that I attempted to grab the
9 mask; but, you know, Amy is one who would like stop
10 you if you are doing something wrong. So I might
11 have, by my usual habit with general or regular
12 intubations, habitually picked up the mask to
13 ventilate.

14 Q So is it true that an LMA is used when a
15 patient is breathing on their own without a muscle
16 relaxant?

17 A Yes, but there is times when if they're
18 given a little bit more of a sedative called Versed
19 that they don't breathe enough times that you would
20 have to assist them by changing the vent settings.

21 Q So I think she is saying here that you
22 were trying to use a mask when it wasn't required; is
23 that right?

24 A Yes, but I'm not sure that it meant I

Page 172

1 actually had the mask on the patient or I attempted to
2 get the mask to attempt to ventilate the patient.

3 Q Later on in this paragraph there is a
4 sentence that starts: At this point we had a
5 discussion about how ventilation. Do you see that?
6 It's after the number 30-34.

7 A On the second paragraph?

8 Q At this point the sentence starts.

9 A Okay.

10 Q At this point we had a discussion about
11 how ventilation through LMA differs from that of the
12 ETT and how ET CO2 is variable with LMA because the
13 patient is spontaneously breathing.

14 Did you have that conversation?

15 A I think so.

16 Q Then it says: Later, closer to the end of
17 the case, I asked Maricel what criteria were needed to
18 remove the LMA, specifically which command we ask the
19 patient to perform. She told me we needed to check
20 head lift, hand strength and minute ventilation. Did
21 that happen?

22 A I believe that's how I answered her.

23 Q Then she indicates there is no mention of
24 telling the patient to open her mouth, and it took

Page 173

1 many questions from me for her to realize no muscle
2 relaxant had been given; therefore, it was unnecessary
3 to check strength by head lift or hand grasp. Is that
4 right?

5 A From what I recall, she had asked what are
6 the signs that indicate to you the patient is ready to
7 be extubated if they had an LMA; and I gave her these
8 different signs which really is for like a regular
9 intubation because in our textbooks there is not
10 really a specific sign that indicates for an LMA
11 intubated patient, what other symptoms you look for
12 aside from the regular objective signs that the
13 patient shows that they're ready to be extubated.

14 Q Let me ask you this: If you were saying
15 that you needed to check head lift, hand strength, and
16 minute ventilation, are those things you check to see
17 if the muscle relaxant is finished and isn't affecting
18 the patient anymore?

19 A Yes, and so it is with sedatives like
20 Fentanyl; or sometimes with anesthesia gases, like you
21 can depress their respiratory effort that you want to
22 see that they're performing or they're putting out
23 adequate minute ventilation.

24 Q So if there was no muscle relaxant, then

Page 174

1 is there no reason to look for those signs?

2 A It's mainly indicated I guess for the
3 muscle relaxant in terms of raising your head, but the
4 other ones are also noticeable with when you are
5 providing just regular sedation with opioids or with
6 anesthetic gases.

7 So the hand strength, minute
8 ventilation, that could be something you could observe
9 for patients who are not given muscle relaxant.

10 Q Isn't she telling you here though that it
11 was unnecessary to check those things because there
12 wasn't a muscle relaxant?

13 A I think I erroneously mentioned check head
14 lift because that's indicated when somebody had a
15 muscle relaxant. But if a patient doesn't follow
16 commands like lifting their head because they're still
17 pretty well sedated, then that could still be
18 interchangeable with regular sedatives and regular
19 anesthetics. So I don't think I was erroneous in
20 mentioning that other symptom.

21 Q She did though; right? She thought you
22 were wrong; right?

23 A That's her indication there, sure.

24 Q And she goes to be say that this is kind

Page 175

1 of a basic concept of anesthesia, right, that if you
2 are using an LMA, you should know to use it correctly.
3 Do you agree that's a basic element after of a CRNA
4 role is knowing how to use an LMA correctly?

5 A Yes. It's a basic understanding or basic
6 knowledge that the CRNA must have, but it's not -- If
7 we're saying we're including open your mouth is one of
8 the basic concepts, that's something that we didn't
9 really see in our textbook.

10 Q So doesn't every patient either get -- You
11 know, you have to affect their ability to breathe
12 while they're under anesthesia; right?

13 A Yes.

14 Q And the basic approach is either an LMA or
15 an ETT?

16 A ETT tube, yes.

17 Q So it talks in the next paragraph: The
18 following case involved an anesthetic with an ETT, and
19 she says you again had difficulty placing the patient
20 on the correct ventilation mode; is that right?

21 A Yes. Well, I had instinctively I think
22 picked a pressure support. I think we started out
23 with volume control; and then she was asking me
24 because, from what I recall, there was something

Page 176

1 pressing on top of the patient. So his ability to
2 expand his lungs was compromised. So we had to switch
3 to a different mode.

4 And since I was still trying to figure
5 out the functionality of pressure support versus
6 pressure control ventilation, that's when I got a
7 little confused as to the modes that I should use.

8 Q Were you trying to use the mode for an LMA
9 setting for a person --

10 A No.

11 Q -- who couldn't breathe on their own?

12 A This is an ET tube.

13 Q I know. So they can't breathe on their
14 own; right?

15 A No.

16 Q Let me ask it a different way. With the
17 ET tube they need help breathing?

18 A Yes.

19 Q And were you choosing a mode that could
20 apply the LMA?

21 A We have used pressure support for ET tube.

22 Q Could it also be used for LMA?

23 A Sure, yes.

24 Q Did it create this apnea ventilation

Page 177

1 problem that's noted here?

2 A This triggered?

3 Q It says: This triggered apnea ventilation
4 and again took prompting from me as to which mode
5 might be a better choice. So do you know, did your
6 initial choice trigger apnea ventilation?

7 A It possibly did.

8 Q And were you then prompted by Miss Gawura
9 to make a different choice about the mode of
10 ventilation?

11 A From what I recall, we were discussing
12 like what other modes could be used. That's when she
13 suggested maybe switching to pressure control
14 ventilation.

15 Q Did you think about attempting to increase
16 title volumes by increasing PEEP after it had been
17 discussed?

18 A So she was asking me how this should be,
19 how we should troubleshoot this; and I was thinking
20 out loud the things that it could possibly do. But I
21 think -- I'm not exactly sure of the details of how it
22 went after that. Like I suggested ways to correct it,
23 and things improved afterwards.

24 Q She says here at the end of that

Page 178

1 paragraph: It was clear to me at this point she does
2 not know how to appropriately manage patients on the
3 ventilator which anesthesia is a life-saving piece of
4 equipment. Let me ask this: Is the ventilator in
5 anesthesia a life-saving piece of equipment?

6 A Yes.

7 Q Do you have any reason to think that she
8 didn't believe this judgment she renders here which is
9 you didn't know how to appropriately manage patients
10 on a ventilator?

11 A I think this was one incident out of so
12 many other instances that I effectively managed cases
13 that involved anesthesia machines.

14 In this one instance I was under
15 extreme pressure from the previous negative
16 evaluations that I had been getting, and the threats
17 by Dr. Kremer that I could be expelled after two
18 negatives evals had affected my thinking or my
19 concentration in managing this particular case.

20 So I was told, You've had two
21 negatives, and it will be an Herculean task to pass
22 this program which Dr. Wiley piled on by saying, It's
23 not impossible, but it's going to be very difficult.

24 With that in mind, I was in some ways

Page 179

1 starting to be caught up with the stress and had
2 thought of going to Miss Gawura for guidance.

3 Q By this point, July 3, '07 -- we have gone
4 over many evaluations -- you have had four or five
5 negative evaluations, right, unsatisfactory
6 evaluations?

7 A They pointed out the three that were like
8 with Alida Hooker included; but the other two like
9 with Dr. Wiley in terms of the two, I disputed that.
10 And so, yeah, I was under extreme pressure thinking,
11 having those in mind.

12 Q The pressure from receiving unsatisfactory
13 ratings and knowing you might fail out; right?

14 A Yes.

15 Q And then on this day, July 30 there
16 actually were two problems that happened, right, two
17 different patients with problems --

18 A Yes.

19 Q -- that we just went over; right?

20 A Yes.

21 Q And when you say you wanted to talk to Amy
22 Gawura, you sat down and talked to her after this?

23 A Yes.

24 Q After these cases that day; right?

Page 180

1 A Yes.

2 Q She goes on to say here in this narrative
3 that you told her, that you sat down and had a long
4 discussion about your performance; and it says,
5 Maricel indicated to me she was under tremendous
6 amount of stress while being on clinical probation.
7 Her anxiety was overwhelming to her and she frequently
8 had a mental block.

9 Did you tell her that?

10 A From what I recall, yes, I told her the
11 stress I was going through.

12 Q Did you tell her you had a mental block
13 when trying to perform tasks and skills required of
14 you?

15 A I might have mentioned that term to her.

16 Q Did that lead her to suggest that you take
17 a leave of absence?

18 A I think she had said, yeah, take two weeks
19 off to clear your mind to help I guess get better
20 control of your anxiety.

21 But the one thing she also said was,
22 This is not the end of it but maybe try to recalibrate
23 by taking some time off.

24 Q So on balance would you agree that Amy

Page 181

1 Gawura's assessment of your performance as
2 unsatisfactory in both of these patients on this day
3 was correct and accurate?

4 A Well, so I'm thinking about just getting
5 zeros for, you know, things that I actually did do,
6 like having a plan of care for those patients. So I
7 didn't get any credit for some things that did go
8 right in these aspects, in these categories.

9 Like that was the whole day. So there
10 were certain things that did go well or that I was
11 able to address, so it was not like a whole -- It
12 wasn't like the whole time she was holding my hand. I
13 was still performing during these different cases.

14 But I felt that getting a zero even to
15 like preps that I already did or things that I did
16 correctly, I did not get any credit at all, it's
17 almost like I just stood there and did nothing. So I
18 don't agree with just getting a zero even though I did
19 participate in and perform some of the acts
20 effectively.

21 Q Well, she didn't give you zeros in
22 everything; right?

23 A No.

24 Q She gives you twos and threes and fours in

<p style="text-align: right;">Page 182</p> <p>1 many categories, didn't she?</p> <p>2 A She did.</p> <p>3 Q Are you saying that these problems that we</p> <p>4 talked through here that you agree we're accurately</p> <p>5 recorded, that they weren't significant problems?</p> <p>6 A Well, they were problematic in the sense</p> <p>7 of my state of mind then, you know. That's why I came</p> <p>8 to her, that I needed guidance, a student who is still</p> <p>9 learning and going through training.</p> <p>10 So their role as educators or</p> <p>11 instructors is to help us sort out our imperfections</p> <p>12 and also learn from our mistakes. It is also part of</p> <p>13 their job to direct us appropriately and not persecute</p> <p>14 us for mistakes that the student normally could make.</p> <p>15 I'm not the first one to have made</p> <p>16 these mistakes, and I don't imagine students would be</p> <p>17 put on probation every time they made a similar degree</p> <p>18 of mistakes.</p> <p>19 Q Based on what do you make the assessment</p> <p>20 that other students wouldn't be put on probation for</p> <p>21 the series of mistakes that you were making? What's</p> <p>22 your basis for that belief that other students</p> <p>23 wouldn't be put on probation for that?</p> <p>24 A Just from my classmate, recalling another</p>	<p style="text-align: right;">Page 184</p> <p>1 A Is there another page?</p> <p>2 Yes.</p> <p>3 Q At the bottom is that your signature but</p> <p>4 then crossed out?</p> <p>5 A Yeah. I'm not sure what happened there.</p> <p>6 Q You don't remember? Did you sign it and</p> <p>7 then cross it out?</p> <p>8 A I don't recall this particular one. What</p> <p>9 I recall was the improvement form that I received when</p> <p>10 I came back from the leave of absence.</p> <p>11 Q So the handwriting at the bottom says:</p> <p>12 Reviewed evaluations and Academic Improvement Form</p> <p>13 with student from 3:45 to 5:45 p.m. on 7/1/13?</p> <p>14 A Yes.</p> <p>15 Q Do you remember talking with Mike Kremer</p> <p>16 on July 1st about evaluations and what they meant?</p> <p>17 A Yes. I think I recall having a meeting</p> <p>18 with him.</p> <p>19 Q The form itself, underneath the course</p> <p>20 number there is a paragraph that includes a sentence</p> <p>21 that say: These behaviors if not addressed put the</p> <p>22 student at risk for receiving a non-passing final</p> <p>23 grade in this course. This is a notification that the</p> <p>24 above student is not meeting the passing standards set</p>
<p style="text-align: right;">Page 183</p> <p>1 student overdosing the patient; but there was no</p> <p>2 consequence to that person, and that person went on to</p> <p>3 graduate and another person giving the wrong drug and</p> <p>4 not being held back or not having the same degree of</p> <p>5 scrutiny that I got after these mistakes that are</p> <p>6 egregiously dangerous to patients.</p> <p>7 Q Do you agree that you deserved some</p> <p>8 unsatisfactory ratings from Amy Gawura for both of</p> <p>9 these patience this day?</p> <p>10 A Well, some of these things that did</p> <p>11 happen, that was brought about by me being under</p> <p>12 stress.</p> <p>13 Q But you do agree you deserved</p> <p>14 unsatisfactory ratings for some of it then?</p> <p>15 A For some of it, yes.</p> <p>16 (Marcial Deposition Exhibit No. 5</p> <p>17 was marked for identification.)</p> <p>18 Q Do you recognize what's been marked as</p> <p>19 Exhibit Number 5, Maricel?</p> <p>20 A Yes.</p> <p>21 Q It looks like an Academic Improvement Form</p> <p>22 dated July 1st, 2013; is that right?</p> <p>23 A Yes.</p> <p>24 Q And did Mike Kremer give this to you?</p>	<p style="text-align: right;">Page 185</p> <p>1 for this course.</p> <p>2 Was that communicated to you, that you</p> <p>3 were at risk of not passing?</p> <p>4 A Yes.</p> <p>5 Q And then in the comment section there is a</p> <p>6 reference to clinical evaluations for June 11, 2013</p> <p>7 and June 20, 2013 have unsatisfactory ratings in the</p> <p>8 areas of safety patient, clinical judgment, and</p> <p>9 professionalism. It indicates that those evaluations</p> <p>10 are attached for review; and evaluation from June 27,</p> <p>11 2013 describes issues with preoperative assessment.</p> <p>12 Do you remember talking through those</p> <p>13 issues with Mike Kremer on July 1st?</p> <p>14 A I don't know the exact details; but I</p> <p>15 imagine that I had met him that day, that we had</p> <p>16 talked about these particular evaluations. I don't</p> <p>17 recall the exact detail.</p> <p>18 Q Part 2 indicates a plan of action. Met</p> <p>19 with student on July 1st, 2013, discussed need for</p> <p>20 consistency and clinical performance and consequences</p> <p>21 for unsatisfactory ratings in areas of patient safety;</p> <p>22 i.e., a grade of no pass for NRS 600 PA. Continue to</p> <p>23 work on consistency and clinical performance.</p> <p>24 Discussed availability of counseling center's</p>

Page 186

1 services.

2 Did you discuss those issues?

3 A I recall the counseling service advice and
4 of course the standards for passing, but I'm not
5 sure -- I think I had asked him like how many negative
6 evals are you, would you have to have to be failed.
7 I think that's one of the things we discussed. But
8 from my recollection, I think I also disputed these
9 evaluations during that meeting.

10 Q Do you remember anything else about what
11 you discussed in that meeting?

12 A This was about a two-hour period, so there
13 is a lot to remember. I think part of it was just
14 doing a rebuttal on these evaluations. And the 6/27,
15 I don't recall which evaluation that is. So I'm not
16 clear to me the details of it. This was five years
17 ago.

18 Q About that discussion?

19 A Yeah.

20 Q But do you remember being informed that in
21 the beginning of July that -- Let me back up.

22 There is as reference in the document
23 we were looking at from Amy Gawura that talked about
24 you being on probation?

Page 187

1 A Yes.

2 Q Did this document we're looking at now,
3 Exhibit 5, provide you with that understanding that
4 you were at risk of failing out and that your
5 performance needed to be better?

6 A Yes, because I had that meeting with them
7 already where they said two strikes and you are out or
8 a Herculean task to pass after these two negatives.
9 So I interpreted that to mean that I was under
10 probation for those two negative evaluations.

11 Q And after that you had -- We looked at
12 these. You had several other unsatisfactory ratings;
13 right?

14 A Yes.

15 Q One from Alida Hooker, some from Judy
16 Wiley, and then the one from Amy Gawura?

17 A Yes.

18 Q So by the time you were evaluated by Amy
19 Gawura on July 30, there had been five unsatisfactory
20 ratings; right?

21 A Yes.

22 Q By five different CRNAs?

23 A Yes.

24 Q At that point in time did you decide to

Page 188

1 take a leave of absence?

2 A I think I had presented to him the
3 intention to take a leave of absence because my
4 physical, my health was being affected by the stress
5 of what I was going through; and I had spoken to
6 Dr. Wiley.

7 Dr. Wiley was initially there; and then
8 I had presented, you know, for a leave between two
9 weeks to one month to them, Dr. Wiley and Dr. Kremer.
10 And Dr. Kremer said, I don't know if we have one for
11 students which Dr. Wiley interjected, Of course we do.
12 You can decide to take a two or one month, two week or
13 a one-month leave and make up for it during the
14 holidays, like Thanksgiving so you could still be on
15 time with graduating.

16 So then Dr. Kremer had to leave
17 somewhere, I think for a meeting; and Dr. Wiley and I
18 had discussed how I was going to time this leave of
19 absence.

20 So in my impression, Dr. Wiley's
21 suggestion or like recommendation of a two-week to a
22 one-month leave was what I was going to be allowed to
23 have; and that's where we left it in that meeting from
24 what I recall.

Page 189

1 Q Was part of the reason you were seeking a
2 leave of absence to avoid being dismissed from the
3 program?

4 A No.

5 Q No?

6 A No.

7 Q Wasn't that probably what was going to
8 happen if you didn't take a leave?

9 A Well, they didn't really indicate how many
10 negatives I had accrued for me to be failed. Plus, I
11 had disputed the other negative evaluations. They
12 didn't really say that they're still considering it as
13 valid despite my contention against it and my
14 rebuttals.

15 And so my main goal was to just clear
16 my mind; and I had been seeing the counselor, the
17 school counselor by that time, and she was the one who
18 suggested that I take a leave of absence for my own
19 mental and physical health.

20 And I had explained this to Dr. Kremer,
21 that I was losing weight, was very insomniac and
22 losing my hair.

23 Q I'm sorry to hear that, that that was what
24 you were experiencing.

Page 190

1 When you say you were seeing a
2 therapist, was that --

3 What was that person's name?

4 A That was Dr. Terrebossy who then directed
5 me to see Dr. Kramer who was a psychiatrist.

6 MR. LAND: Do you want to take a short break?

7 THE WITNESS: Yes, please.

8 (Whereupon a brief recess was had,
9 after which the deposition of
10 Ms. Marcial continued as
11 follows:)

12 MR. LAND: Could you mark this 6.

13 (Marcial Deposition Exhibit No. 6
14 was marked for identification.)

15 Q Maricel, if you look at what's been handed
16 to you and marked as Exhibit Number 6 for your
17 deposition, it's documents that we received from your
18 therapist, Terrebossy?

19 A Terrebossy.

20 Q These are just all of the documents that
21 we received from that therapist.

22 What's Terrebossy's first name?

23 A Hilarie.

24 Q So on the first page it appears to

Page 192

1 suggested a leave of absence which I supported. So
2 were you talking to her about the possible leave of
3 absence?

4 A Yes, because I wasn't sure how to survive
5 basically; so she had suggested a leave of absence.

6 Q So that was after the review, the critical
7 review from Amy Gawura? That's another negative
8 evaluation that's referenced here.

9 A I'm not sure. I mean based on this date,
10 it's my recollection it seems to overlap. I thought
11 that she had suggested for me to look for a mentor,
12 and that's why I thought of confiding initially to
13 Miss Amy Gawura. So like the date's just --

14 Q Forgetting the dates, did you confide in
15 Amy Gawura before the July 30 date where you had the
16 problems with the two patients or after the problems
17 with the patients and at the end of that day?

18 A At the end of the day.

19 Q And that was July 30, and then is this
20 looks like August 2nd you are meeting with the
21 therapist?

22 A Okay.

23 Q I reference that, and then the next page
24 is information she actually -- No. Mine is slightly

Page 191

1 indicate that July 24, 2013 was your initial
2 appointment; is that right?

3 A The 24 of July?

4 Q Yeah.

5 A It appears that, yes.

6 Q There are notes that say: This woman is
7 in residency portion in the program, and then it says
8 is in danger of dismissal due to several poor
9 evaluations that she has received from CRNAs Jill and
10 Eva who appear to be close friends.

11 Did you tell the therapist that you
12 were in danger of dismissal due to several poor
13 evaluations?

14 A I believe I disclosed that to her.

15 Q Then there is some handwritten notes that
16 start at the bottom of this page?

17 A Yes.

18 Q From it looks like another visit,
19 August 2nd, 2013?

20 A Uh-huh.

21 Q Is that right?

22 A Yes.

23 Q It indicates: Met with program head
24 yesterday following another negative evaluation. One

Page 193

1 different, but the second page they have Bates numbers
2 at the bottom; right?

3 A Yes.

4 Q So Terrebossy Number 2?

5 A Yes.

6 Q That follows up on the notes from
7 August 2nd, the second page; right?

8 A Yes.

9 Q In those notes on the second page
10 three-quarters of the way down, it starts to say: She
11 had scheduled an appointment with L. Alstead
12 (phonetic) --

13 Do you see that?

14 A Yes.

15 Q -- but decided to cancel it when it became
16 evident that her program is willing to work with her;
17 right?

18 A Yes.

19 Q So you were learning that you might be
20 able to work out a leave of absence; right?

21 A Yes.

22 Q Then the next set of notes looks like it's
23 from a third meeting with Terrebossy on August 8,
24 2013?

Page 194

1 A Uh-huh.

2 Q Took LOA which will last about three and a
3 half months. This is instead of failing current
4 rotation and being dismissed. Do you see this?

5 A Yes.

6 Q Did you tell Terreberry that?

7 A My perception was that it's a -- Well, I
8 didn't tell her the grade that I was given; and my
9 perception of that grade which was WM I think was that
10 it was not a final grade, that they are allowing me to
11 remediate when I come back.

12 So I think what I told her was that I
13 was being given a chance to redo my time of being away
14 on a leave of absence.

15 Q Wasn't the arrangement that the grade you
16 just referenced that was not a failing grade was part
17 of the agreement for leave of absence, to give you a
18 chance to come back and try to adjust your
19 performance?

20 A That was what was imposed on me because
21 Dr. Kremer said that you can't really take a leave in
22 the middle of the quarter. You have to take, you
23 know, you have to be graded according to -- because he
24 consulted with Dr. Johnson I guess, the Associate

Page 195

1 Dean, that if we were going to give you this leave,
2 then we have to assign a grade because you are midway
3 into the quarter from what I recall.

4 And so under duress I had to agree with
5 that so I could just proceed with getting my leave.
6 So I really was not given a choice of --

7 Q If you had stayed, did you think you had a
8 chance of passing the course?

9 A Not in my state of mind then and I felt
10 like under the stress that I was going through. If I
11 was given a shorter leave, like two weeks to one
12 month, I might be able to not fall as behind as I did
13 with like August, September, October, November,
14 December, almost five months of being away which
15 Dr. Terreberry was not, when I had to tell her that,
16 she wasn't happy about that recommendation because she
17 said it's just going to delay me and cause my skills
18 to atrophy because I have no chance of being exposed
19 to clinicals. Whatever I'm studying, I won't be able
20 to apply in actual situation even though I made up
21 some opportunities to do clinicals with
22 anesthesiologists I know, yeah.

23 Q I guess what I'm wondering, so was Rush's
24 approach to allowing you time away instead of staying

Page 196

1 with the course and getting a grade, was that in some
2 way like beneficial to you from a grading perspective,
3 like lenient instead of dismissing you for failing the
4 course and giving you a chance to regroup and come
5 back, aside from how long the leave was?

6 A Can you ask that again?

7 Q Was it lenient of Rush to try to allow you
8 time off so that you could try to regroup and come
9 back and perform better as opposed of taking the five
10 unsatisfactory ratings and applying that to a grade?

11 A I wouldn't call that lenient in the sense
12 that if I contested the other negative evaluations, I
13 don't know why they would consider or like add that
14 into my grading.

15 And so I didn't consider myself as
16 failing them despite these negatives evals because I
17 knew that I was able to be effectively refute them,
18 and they didn't investigate or do enough to look up
19 the validity of my statements because there were
20 certain times that the documentation would reflect
21 what I was saying in my rebuttals; and I suggested to
22 Dr. Kremer, why don't you compare my documentation
23 with what such and such CRNAs are putting in my
24 evaluations so you could validate that what I'm saying

Page 197

1 is true.

2 And so I don't think it's lenient
3 inasmuch as it's fair for me to take that leave
4 without the risk of being failed.

5 Q Okay. Later in these notes on this page
6 it talks about, Talked regarding her tendency --

7 Do you see that?

8 A Yes.

9 Q -- to explain too much, to defend her
10 decisions or actions when she has been corrected
11 rather than accept the correction and agree to doing
12 it in a specified manner the next time. She
13 acknowledged that she does this, sees how it can be a
14 problem.

15 Did you talk about that with
16 Terreberry?

17 A I took in her observation based on what I
18 presented to her. And she was recommended to me by
19 another SRNA, and I'm not sure if she is also gauging
20 it from the experience of that other SRNA as to my
21 experience as well.

22 But I was taking in her advice without
23 necessarily thinking that I don't know if I've given
24 her enough to say that I was talking a lot and

Page 198

1 refusing correction.

2 Q But did she talk to you -- I guess I'm
3 just asking. Did she talk to you about having a
4 tendency to defend yourself rather than accept
5 correction and agree to learn from it? Did she talk
6 to you about that?

7 A She said to just take in the instruction
8 and try not to defend yourself so you don't come off
9 as resistant from what I recall.

10 But I took it in as, okay, this is
11 advice that maybe I should be internalizing or taking
12 in and recognize that, you know, this might improve my
13 interaction later.

14 Q I mean here it says she acknowledged that
15 she does this?

16 A Yes.

17 Q Sees how it could be a problem. Is that
18 accurate about what you told Terreberry?

19 A At that time, like I said, I expressed my
20 agreement with her advice; but I didn't really state
21 that there was a particular like cause and relation to
22 my behavior and the problem that I was experiencing.

23 Q If you look further down the page, it
24 looks like another set of notes from another visit

Page 199

1 with Terreberry of August 13, 2013; and it talks about
2 urged, halfway down, urged her to accept this outcome
3 and work on fixing problem that led up to it.

4 Do you see that?

5 A Yes.

6 Q Then after that, specifically talked with
7 her regarding tendency to challenge authority of
8 people over her but appearing to question them or
9 explaining her reasons for handling things the way she
10 did. Do you remember talking about that with
11 Terreberry the second time in a meeting?

12 A I think she made that recommendation, that
13 maybe I should just sit back and not speak out, just
14 to keep myself, like what my classmates would often
15 say, stay under the radar and not make too much noise
16 so you don't get picked on.

17 And that's how she referred to as, when
18 we speak out or try to rationalize our way of thinking
19 things through with how we're performing our tasks,
20 that's how she explained to me, that that may come out
21 as resistant to their, to authority's handle on us.

22 And so I think her stance is to just to
23 back off and not to try defend yourself or rationalize
24 your actions so that you don't I guess offend them or

Page 200

1 make them feel like you are being resistant.

2 Q If you could turn to Page 17 of this --
3 I know we're getting close to 4:00 o'clock, real
4 close; but I do have a few questions to ask you.

5 This appears to be something you wrote
6 and sent to Terreberry?

7 A Which one, the bottom one?

8 Q The bottom part of it, both of them, but I
9 am looking at the bottom part, other notes from
10 October 24.

11 A Okay.

12 Q Did you create those?

13 A Yes. This is my email to her I believe.

14 Q So if you go under the other notes from
15 October 24, if you go to the third paragraph, the
16 second sentence starts: He was somewhat apologetic --

17 Do you see that?

18 A Yes.

19 Q -- about the incidents of how to deal with
20 Jill and Eva and concedes that in the ER there are
21 plenty of personalities which could be difficult or
22 challenging but reassured me that he will inform Ray
23 to limit my interaction with them in clinicals. Do
24 you see that?

Page 201

1 A Yes.

2 Q So Mike told you he would inform Ray to
3 limit your interaction with Jill and Eva --

4 A Yes.

5 Q -- when you returned?

6 A Yes.

7 Q So that's different than no interaction;
8 right?

9 A Yes.

10 Q So that means there could be some?

11 A Potentially is what I thought, but okay.

12 Q Then two paragraphs down from that, the
13 one that starts we again revisited, do you see that?

14 A Okay.

15 Q You are describing, We again revisited the
16 terms for the LOA and said that in the first month of
17 my return, I will be assigned to a CRNA (I was a
18 little surprised as I thought that since I was still
19 on probation that I would still need a full three
20 months of CRNA supervision.)

21 So he told you that would be the case
22 when you came back, one month of CRNA supervision?

23 A Yes.

24 Q Then the last sentence, it starts in that

Page 202

Page 204

1 page, He said, I'm sure Ray will try to ease you into
2 it by starting you with simple, not so challenging
3 cases at the beginning, and so I just need to know the
4 basics (got the impression that he was reassuring me
5 that I don't need to be at the level I was in before
6 LOA when I came back). Then in quotes: "Nonetheless,
7 cases change easily, so be prepared and flexible to
8 take whatever he assigns you to do."

9 Is that a quote of what Mike said to
10 you, what Dr. Kremer said to you?"

11 A I was recalling that after our meeting, so
12 not verbatim but most of what, the substance after
13 what he said.

14 Q Okay. So it seems he's telling you that
15 the cases that are assigned might be limited or
16 attempt to be adjusted so that you could start back up
17 but that you need to be ready for anything because
18 things could change; right?

19 A Yes.

20 Q There is some areas in what you've sent
21 along here that include quotes, sometimes long quotes.
22 Did you tape-record any conversations with anyone
23 relating to the SRNA program?

24 A This particular one, this particular

1 Q Do you still have that recording?

2 A Yes.

3 Q Have you produced it to your lawyer?

4 A I believe I gave it to her.

5 Did we submit it?

6 MS. SIEGEL: No.

7 A Not yet, but we had mentioned it to her.

8 MR. LAND: Elaine, we're going to need that
9 recording.

10 MS. SIEGEL: I understand.

11 MR. LAND: Q Did you tell them they were being
12 recorded?

13 A No. It was just more for me to remember
14 what was going on.

15 Q Do you know that there are legal
16 requirements relating to recording conversations?

17 A No.

18 MS. SIEGEL: I object. It relates to a legal
19 conclusion.

20 MR. LAND: I'm not asking for a legal
21 conclusion, just her knowledge.

22 Q You don't know?

23 A No.

24 Q Why did you record it?

Page 203

Page 205

1 meeting, no.

2 Q I asked a slightly different question.
3 Did you ever record any conversation you had with
4 people at Rush about the SRNA program?

5 A With Dr. Johnson and Dr. Kremer, just so I
6 can remember what they were saying coming back.

7 Q What do you mean?

8 A I think it was November that I had a
9 meeting with them.

10 Q And you tape-recorded it?

11 A I believe so.

12 Q What do you mean?

13 A Yeah. I did.

14 Q Did they know you were doing that?

15 A I don't know if I had informed them.

16 Q How did you record it?

17 A Just on my iPhone.

18 Q Was your iPhone hidden when you were doing
19 that?

20 A It was on my purse.

21 Q In your purse?

22 A Yes.

23 Q So they couldn't see it; right?

24 A Yes.

1 A Because I wanted to be aware of the
2 details and make sure that it could help me later to
3 recall the requirements of what was really said.

4 Q Why didn't you ask them if you could
5 record it then if that was the reason?

6 A I'm not sure. I didn't think it was a big
7 deal to do it since it's mostly for me remembering
8 details as a guide for when I come back.

9 Q You didn't think that would matter to
10 them, that they were being recorded?

11 A I guess I didn't think of that.

12 Q Really?

13 A No.

14 Q What other conversations relating to the
15 SRNA program did you record?

16 A With my classmates? We had text messages.

17 Q Any conversations you had with people at
18 Rush that you recorded. That's what I'm asking about.

19 A There is nothing else because this is,
20 like I said, this is primarily for me, like a
21 checklist for me. So that's the only recording I
22 made.

23 Q You're sure you didn't record any other
24 conversations?

Page 206

Page 208

1 A Yes. I'm sure.
 2 Q You hesitated a little bit there.
 3 A No. I'm sure I haven't recorded anything
 4 else except that.
 5 Q Did any of the quotes that you put into
 6 documents come from recordings?
 7 A No.
 8 Q None?
 9 I'm just asking you: Do you ever
 10 remember using a recording to create a document with
 11 quotes?
 12 A Yes.
 13 Q What did you do with that document?
 14 A Oh, you mean for -- Not for this
 15 particular one. I'm using quotes because I'm trying
 16 to reproduce their verbatim statements, but it's not
 17 necessarily the exact words that they said. So this
 18 is not from a recording. This is from my memory.
 19 Q What I asked is: Did you ever use the
 20 recording to create documents that quoted people from
 21 the recording, and you said yes?
 22 A No. I didn't create documents that I
 23 pulled from recording that I recall.
 24 Q So maybe you did but you are not sure?

Page 207

1 A I know that I didn't use it to produce a
 2 document, any of the things in the recording except
 3 for my, the things I need to remember, not necessarily
 4 the statements they made.
 5 Q The last thing I want to ask you about
 6 before we break is the next paragraph on Page 18 of
 7 the Terreberry documents. So it's the paragraph that
 8 starts as far as evaluations.
 9 Do you see that? I just want to know
 10 if you see that paragraph. It's the one at the top,
 11 this one there.
 12 A Okay.
 13 Q So it says: As far as evaluations, he,
 14 that's Mike Kremer; right?
 15 A Uh-huh.
 16 Q He repeated that if unsatisfactory evals
 17 start coming again, that I will get a verbal warning
 18 at first, then second time around a written warning,
 19 and if things don't go well, then we can talk about
 20 transitioning me to CNL (Clinical Nurse Leader)
 21 program so I can get full credits for all of the
 22 courses I've taken before. I agreed to all of the
 23 aforementioned conditions.
 24 Did that happen?

1 A Yeah. I had a verbal, you know --
 2 I agreed to him then in October when we had this
 3 discussion.
 4 Q So you agreed that if you got
 5 unsatisfactory evaluations you'd get a verbal warning
 6 first and then the second time you got one you'd get a
 7 written warning and if things didn't go well after
 8 that you would talk about transitioning?
 9 A Yes. That is back in October.
 10 Q I understand. But this is setting up how
 11 things would work when you came from your leave of
 12 absence; right?
 13 A Yes.
 14 Q You clearly understood that when you got
 15 back, if you got unsatisfactory evaluations there
 16 would be consequences, and by the third one you might
 17 have to talk about transitioning; right?
 18 A Yes.
 19 Q And you agreed to that; right?
 20 A I agreed to it then.
 21 Q You said that like three times now. I'm
 22 not sure what you mean.
 23 A Because when we had another meeting with
 24 Dr. Johnson and Dr. Kremer, I had stipulated that I

Page 209

1 will sign a contract only if you can assure me that
 2 there would be no -- because this was before my talk
 3 with Narbone, and I had requested that with this
 4 contract they add that somebody should oversee the way
 5 I'm being treated, if there is any forms of bias or
 6 discrimination, that somebody should intervene and not
 7 consider the merits of their evaluations.
 8 And so I was presenting that based on
 9 how I was treated by Ray and the things that he had
 10 said that would almost guarantee my failure even
 11 before I came back.
 12 Q Okay. And I think you're saying that you
 13 had this subsequent discussion and it was in the
 14 meeting that you recorded?
 15 A Yes.
 16 MR. LAND: I think we should break for now.
 17 MS. SIEGEL: Sure.
 18 MR. LAND: Off the record.
 19 (Whereupon the deposition of
 20 Ms. Marcial was adjourned.)
 21
 22
 23
 24

Page 210

1 UNITED STATES DISTRICT COURT
2 NORTHERN DISTRICT OF ILLINOIS SS.
3 EASTERN DIVISION
4
5

6 I have read the foregoing transcript of my
7 deposition, taken on February 28, 2018, consisting of
8 pages 1 through 209, inclusive, and I find it is a
9 true and correct transcript of my deposition so given
10 as aforesaid.
11
12
13
14
15

16 MARICEL MARCIAL

17
18 SUBSCRIBED AND SWORN TO
19 before me this _____ day
20 of _____, 2018.

21 Notary Public
22
23
24

Page 211

1 STATE OF ILLINOIS)
) SS.
2 COUNTY OF COOK)
3
4

5 I, Erin McLaughlin, CSR, do hereby certify
6 that I am a court reporter doing business in the City
7 of Chicago, that I reported in shorthand the testimony
8 given at the deposition of MARICEL MARCIAL, on
9 February 28, 2018, and that the foregoing is a true
10 and correct transcript of my shorthand notes so taken
11 as aforesaid.
12
13
14
15
16

17 Certified Shorthand Reporter
18
19
20
21
22
23
24

A	128:7 154:9	addresses 154:4	64:15 70:15,19	anesthesia 22:8,12
ability 6:4,6 8:19	163:24 167:5,12	addressing 118:22	163:2 207:22	23:11 24:1 32:1
12:8 32:15 36:12	168:11 181:3	131:18 148:16	208:2,4,19,20	32:24 33:8,16
141:7 142:20	198:18	157:2	agreeing 79:6	34:14 35:8 37:16
143:4 168:3	accurately 54:15	add-on 113:18	agreement 37:18	38:24 47:3,5 51:3
175:11 176:1	54:19,22 153:18	adequate 111:7	194:17 198:20	51:23 52:2 67:10
able 22:7,8,10	182:4	173:23	ahead 21:17	121:19 122:9
32:19 37:4 41:8	accused 72:6	adjacent 38:22	air 89:1	135:17,22 142:4
47:24 51:8 108:14	acknowledged	adjourned 209:20	airway 52:4 63:17	145:2 150:16
111:14 120:10	197:13 198:14	adjust 35:11	63:24 64:8 144:13	159:22 162:21
133:17 134:4	act 22:9 78:13	194:18	144:14,16,24	170:20 173:20
137:21 143:13	115:24 152:16	adjusted 121:22	147:20 150:24	175:1,12 178:3,5
181:11 193:20	acted 114:19 162:9	202:16	164:21 165:9	178:13
195:12,19 196:17	165:11	administering	171:4	anesthesiologist
abnormal 150:11	acting 22:13	23:11 166:7	airways 129:16	19:7,12,18 22:10
abnormals 20:22	action 29:11 149:21	advice 186:3	algorithm 48:14	37:15,17 38:21
abrasive 169:5,9,12	185:18	197:22 198:11,20	Alida 57:7,20	45:6,14,15 46:12
absence 14:13,16	actions 9:13 15:19	affairs 47:11	107:14 148:9	50:23 51:5,19
14:19 17:23 40:24	27:9 29:5,7,11	affect 10:15 11:6	149:1 156:24	122:1 142:8
43:23 44:1,3	30:11 89:11	23:10 29:14 116:1	157:19 162:7	162:16
86:19 92:5 100:17	122:23 123:1	143:4 175:11	179:8 187:15	anesthesiologists
102:5,7,13 103:9	153:6,11,13	affords 38:18,19	allegation 9:23	19:2 20:6,9 40:13
103:12 180:17	197:10 199:24	aforementioned	72:4 109:19	40:15 43:11 44:13
184:10 188:1,3,19	actively 115:2,6	207:23	alleged 123:11	44:22 45:8,23
189:2,18 192:1,3	122:12	aforsaid 210:10	alleging 17:13	46:7,14 131:4
192:5 193:20	activity 139:11	211:11	123:22 124:5,14	151:10 162:18
194:14,17 208:12	acts 162:3 181:19	age 7:13 9:24 10:6	allow 5:2 196:7	195:22
abuse 13:11	actual 59:17 106:2	10:8,15,21,24	allowed 39:17,19	anesthesiology
abused 141:3	169:8 195:20	11:6,16,21,21	188:22	51:18
Academic 183:21	add 35:1 196:13	12:20,23 13:21	allowing 194:10	anesthetic 19:14
184:12	209:4	14:21 15:6,10	195:24	174:6 175:18
accept 67:13	added 27:18 115:5	95:22 96:3 98:8	allows 5:6	anesthetics 28:7
197:11 198:4	addition 82:19	121:3	Alstead 193:11	174:19
199:2	135:16 141:23	aged 138:3	amended 6:24 13:3	Anesthetist 23:7
accepting 67:20,24	additional 166:3	agenda 47:11,13	amount 21:14	Angela 86:14,20
account 130:16	address 4:20 10:1	ago 168:11 186:17	180:6	87:5,11,20
140:15	116:12 118:10	agree 22:17 23:9	Amy 59:10,23	answer 5:3,8,17 6:1
accrued 189:10	119:8 120:16	55:20 63:3 64:3,5	86:14 90:4,14	16:24 39:23 70:22
accurate 36:4	128:21 129:3	64:11 105:4 108:5	92:1 168:15,23	89:3,16 131:16
37:11 58:23 63:5	130:14 131:13	144:15 153:17	170:17 171:9	136:16 137:24
63:14 65:1,4,8,11	150:8 153:10	160:10 175:3	179:21 180:24	138:6,9 140:4,5,8
65:15,19 70:6	181:11	180:24 181:18	183:8 186:23	142:18 145:16
85:23 90:14 105:5	addressed 8:17	182:4 183:7,13	187:16,18 192:7	167:15
105:11 107:5	89:22 90:1 92:24	195:4 197:11	192:13,15	answered 16:23
110:10 124:6	131:6 151:15	198:5	analgesia 32:3	125:9 136:15,23
	165:5 184:21	agreed 63:18,22	anatomy 24:22	138:9 172:22

answering 89:13 138:22 139:9 142:17 answers 5:1 89:10 138:1 139:5 Anthony 98:23 99:6 anticipate 5:3 34:23,23 35:2 36:2 anticipating 168:5 anxiety 93:10 180:7 180:20 anymore 115:12 173:18 apnea 176:24 177:3 177:6 apneic 114:6,24 115:3,9,11,14,23 apologetic 200:16 apologized 97:11 141:5 apparently 93:22 appear 101:14 104:18 106:20 116:17 191:10 APPEARANCES 2:1 appeared 2:6,12 157:17,20 appearing 199:8 appears 56:3 58:10 58:22 59:10,15,22 61:13 107:23 163:8 164:6 168:14 190:24 191:5 200:5 application 56:16 apply 32:16,19 176:20 195:20 applying 65:23 170:19 196:10 appointment 191:2 193:11 appraisal 68:15,17 90:16	approach 24:1 81:22 90:11 175:14 195:24 approached 90:24 approaching 45:14 appropriate 29:3 29:19 53:10 66:16 91:1 104:9 110:22 120:12,23 121:3 142:10 143:23 155:10 appropriately 30:23 129:24 178:2,9 182:13 approximate 24:19 approximately 125:4 April 13:15 14:1 55:19,23 56:4 57:20 area 31:20 52:19 areas 185:8,21 202:20 argue 67:10 72:8 93:15 161:2 argued 17:12 165:24 arguing 151:8 arises 33:20 arrangement 194:15 arrests 22:24 art 152:18 articles 31:23 Asian 98:6 Asians 96:20 97:2 aside 23:8 35:5 62:16 93:17 140:8 143:8 144:8 173:12 196:5 asked 5:24 6:5 16:23 40:9 68:21 71:17 89:2,7 90:24 93:10 98:15 104:8 122:6 125:9 125:10 135:1,11	136:1,7,12,17 137:13,22 138:4,7 138:7,15 142:16 142:19 158:21,21 165:16 166:14,18 166:21 167:11,14 172:17 173:5 186:5 203:2 206:19 asking 5:18 68:24 78:22,23 87:12 90:21 103:22 108:6 118:21 124:4 139:3 144:14,16 154:13 166:11 167:18 175:23 177:18 198:3 204:20 205:18 206:9 asks 161:17 aspect 25:2 59:6 158:4 aspects 65:22 67:10 157:13 181:8 assertion 149:12 assessment 163:24 181:1 182:19 185:11 assign 48:15 195:2 assigned 32:1 38:3 47:17 68:18,19 77:5 81:7 83:20 84:2,4,6 201:17 202:15 assigning 47:2 assignments 51:2 assigns 202:8 assist 171:20 assisted 130:7 associate 40:8 194:24 associated 168:8 ASSOCIATES 2:3 assume 5:18 27:5 43:2 assumed 115:15	153:9 assuming 72:6 assure 209:1 assured 127:14 atrophy 195:18 Atropine 28:2 136:17 attach 52:20 attached 52:21 114:23 185:10 attempt 48:3,20 165:14 172:2 202:16 attempted 171:3,8 172:1 attempting 177:15 attempts 8:17 attend 8:17 attending 94:21 attention 51:11 56:2 81:7 161:23 attorney 4:7 attuned 47:24 August 83:18 84:10 92:5,12,22 95:8 101:7 102:14,22 103:10 191:19 192:20 193:7,23 195:13 199:1 authority 199:7 authority's 199:21 autonomy 22:15 availability 185:24 average 68:14 152:16 avoid 189:2 aware 8:7 41:11 122:16 124:22 128:13 205:1 a.m 1:19 <hr/> B <hr/> B 165:13 baby 114:6,18,18 114:21,24 115:8,9 115:11,14,15	122:18 back 12:10 33:6 40:23 55:10,19,23 58:2 60:19 61:11 65:5 72:8 73:19 75:24 76:15 82:20 89:15 93:15 94:18 100:10 106:12 107:11 108:20 113:10 114:21 115:22 116:1 124:8 125:16 126:22 134:4,9 141:21 147:19 148:6 158:6 164:17 183:4 184:10 186:21 194:11,18 196:5,9 199:13,23 201:22 202:6,16 203:6 205:8 208:9,15 209:11 backdated 123:13 124:17,19 125:8 background 18:4 19:8 backup 147:18 backwards 55:21 back-up 118:4 bad 63:10 balance 180:24 barely 128:11,17 base 70:24 72:3 based 7:12 9:5 40:7 48:11 68:16 72:12 110:13 121:1 129:24 131:23 133:2 137:4 138:10 139:11 155:21 162:23 182:19 192:9 197:17 209:8 baseline 152:3 159:3,10,14,14 161:23 bases 7:18
---	---	--	---	--

basic 27:17 51:17 175:1,3,5,5,8,14 basically 33:17 38:23 74:13 121:24 129:15 142:24 150:9,12 159:12 192:5 basics 170:20 202:4 basis 13:21 14:20 16:11 23:2 59:5 62:11 68:8,12 69:23 72:13 97:9 124:18 125:7 126:9 154:21 162:5,12,14 182:22 batch 79:16 80:3 Bates 193:1 bedside 18:14 beginning 45:22 102:10 132:15 136:24 186:21 202:3 behalf 2:6,12 6:13 behaved 96:8,11 behavior 198:22 behaviors 184:21 belief 70:24 72:13 124:18 125:7 182:22 believe 8:2,6,20,22 10:16 12:2,11 14:22 15:24 16:8 17:1,4,11,14 25:1 25:17,20,21 26:9 28:11 32:13 40:16 43:24 54:13 56:11 59:20 62:11 63:11 69:8 70:6,18 72:8 72:24 76:20 78:12 79:11,13 80:7 81:15 82:3,11,17 82:21 83:19,21 84:21 85:7 86:18 87:8 91:7,18 99:10 100:17	102:12 104:18 106:17 109:12,23 123:11,12,21 124:17 126:2 128:2,15 138:9 141:17 142:17 144:19 151:14 154:22 157:2,20 162:7,8 163:23 164:13 165:7 167:5 172:22 178:8 191:14 200:13 203:11 204:4 believed 15:22 17:17 62:19 71:17 86:5 believing 126:9 Ben 73:6 beneficial 196:2 best 14:8 60:12 73:8 107:6 164:1 better 93:16 98:19 177:5 180:19 187:5 196:9 beyond 46:16 bias 154:16 209:5 biased 153:2 154:7 155:14 156:8 164:4 biases 66:17 big 37:23 43:2,6 94:3,14 205:6 bit 18:3 22:3 30:14 44:12 88:3,8 128:16 134:8 143:8 171:18 206:2 BLACKWELL 2:8 blade 91:10 151:4 151:18 158:9,20 blank 86:4 blanket 129:21 block 180:8,12 blood 21:16 52:23 149:13,17 150:11	150:14 152:2 153:24 159:6,13 159:18,20 162:24 Blue 22:23 23:1 Blvd 2:3 board 159:23 160:3 160:12,19,22 body 27:10 29:14 165:18 body's 29:9 book 131:3,24 bother 53:17 bottom 13:4 57:10 58:3 60:18 112:9 112:11 117:19 125:18 156:21 184:3,11 191:16 193:2 200:7,8,9 break 5:21,23 6:1 55:2 62:17 156:15 162:15 190:6 207:6 209:16 breaks 41:6 breast 91:7 breathe 171:19 175:11 176:11,13 breathing 52:7 115:18 171:15 172:13 176:17 brief 55:4 100:4 156:16 190:8 briefly 116:6 151:17 158:6 bring 19:4 bringing 18:19 brought 81:6 159:10 183:11 brushes 146:7 building 52:14 bullet 104:6 106:13 107:12 108:21 125:18 148:7 bunch 63:8 134:6 business 211:6 <hr/> C	C 86:2 164:18 call 4:20 19:19 30:13 31:9,23 38:17 47:4 52:2 52:20 84:5 112:6 196:11 called 1:12 6:13 32:4 41:11 85:18 161:22 167:19 171:18 calls 39:21 48:24 66:6 70:20 78:9 83:10,14 98:20 99:15 117:23 147:9 159:22 Cam 15:21 74:24 97:17 98:1 141:15 cancel 193:15 canister 52:16,18 53:6 capacity 1:7,8,9 capstone 32:4,4 card 30:22 cardiac 18:17 22:23 cards 30:13 care 18:16 20:20,24 22:11,12 24:4 33:16,21,24 35:2 35:8 66:15,16 129:10 130:9 157:2 169:14,15 181:6 carefully 110:20 111:1 118:17 care-giving 122:10 122:22 carry 30:12 cart 157:11 case 7:4,8 8:4 32:2 33:1,9 34:1,10,18 35:6,19 36:6,13 36:23 37:5,13,15 37:21 38:3,13 39:4 45:15 47:6 47:22 49:20,23	50:8 51:2,9,11 56:21 59:1 74:10 74:13 82:8,14 84:24 87:13,21,24 88:12,20 89:7,22 90:2,3,17,21,22 90:23 91:2,3,4,21 91:24 92:2,10,14 92:16,22,24 93:1 93:24 94:8 95:1,2 95:6,19 112:13 113:1,2 114:2 116:14,20,22 117:1,12,13 118:15,15 120:19 120:20,21,24 121:24 122:8,18 129:9,17 132:15 133:3,8,22 134:5 134:7,19 135:23 136:15,24 138:2 141:1,8,10,19 142:21 143:5 144:17 146:2,15 159:24 160:4,7,19 161:15,15 162:2 162:20 163:5,9,21 164:9 165:17 170:4,21 172:17 175:18 178:19 201:21 cases 33:15 34:6 35:15 38:12,14 47:2,4,17 48:1,4,5 63:3 68:19,20 86:7 87:3 88:14 88:23 90:15 92:1 112:24 129:11 130:2,3,4 132:10 132:20 133:9 169:19 178:12 179:24 181:13 202:3,7,15 categories 7:21 8:2 9:1 107:22 128:9 168:21 181:8
---	---	--	---	--

182:1 category 163:18 caudal 135:17,22 caught 179:1 cause 150:16 195:17 198:21 Center 1:6 4:8 7:1 center's 185:24 certain 15:4,7,9 20:18,19 26:22 34:24 47:20,22 48:1 67:10 68:20 87:9 128:8 156:3 181:10 196:20 Certified 211:17 certify 211:5 challenge 199:7 challenging 170:18 200:22 202:2 chance 61:23 140:7 194:13,18 195:8 195:18 196:4 change 33:1,9 36:1 37:23 152:14 153:24 159:9,15 159:17,19 202:7 202:18 changed 36:13 112:14 changes 121:22 151:23 152:5 changing 171:20 characterizations 144:15 cheat 30:13 132:11 132:21 133:13 134:14,15,21 check 51:22 110:8 116:19 131:5 160:7 172:19 173:3,15,16 174:11,13 checking 161:19 166:5 167:17,23 168:1 checklist 205:21	Chicago 1:17 2:4,9 211:7 chief 47:9 child 93:11 94:9 110:8,19 112:6,20 112:23 113:8,9,14 113:16,18,20,22 114:1 121:5,8 139:15,20 child's 93:8 120:12 120:23 chip 91:12 choice 158:23 177:5,6,9 195:6 choose 147:18 choosing 29:3 176:19 circled 108:8 circuit 94:5,16,17 114:5,11,19,23 115:3,4,13 116:4 circumstances 35:11 cisatracurium 28:12 City 211:6 Civil 1:14 4:12 claim 8:8,15 claiming 7:22 9:3 70:10 claims 7:4,8,15,18 7:18 54:10 62:18 62:18 class 31:22 32:6 73:3 classmate 45:11 74:11 96:8 97:4,7 141:10 182:24 classmates 14:24 26:5,8 30:22 44:24 68:14 69:6 69:9,19 75:15 96:12,14,17,22 97:9,22 199:14 205:16 classwork 31:24	clean 52:22,24 clear 178:1 180:19 186:16 189:15 clearly 91:11 142:23 208:14 clicking 137:22 client's 85:17 clinical 8:18 10:19 24:12 25:3,23 26:15 30:6 31:8 31:15,20 32:6,7 32:14,16 36:19 39:13 40:8 41:12 42:3,17 43:4,7 50:8 54:12 55:14 56:21 68:10 98:18 116:10 117:7 130:8 164:9 180:6 185:6,8,20,23 207:20 clinicals 25:5,8,15 25:20 26:11 32:8 32:23 51:6 83:17 195:19,21 200:23 close 30:24 67:9 75:3 102:19 191:10 200:3,4 closer 124:24 172:16 club 31:23 clue 168:6 CNL 207:20 Code 22:23 23:1 Colino 61:14,18,20 62:12 collaborate 18:18 collaborating 20:11 collaboration 37:14 colleague 74:11 96:7 collude 154:23 colluded 70:13 81:16 82:3,21,23 colluding 17:13,15 71:18 72:7,14 73:1,15	collusion 71:1 72:4 74:7 75:1,8 76:23 78:1 79:11,22 80:13 82:18 coloring 155:11,14 come 19:5,7 35:24 43:12 84:7 104:2 114:21 194:11,18 196:4,8 198:8 199:20 205:8 206:6 comes 143:1 coming 75:24 129:17 203:6 207:17 command 172:18 commands 174:16 commencing 1:18 comment 11:2 56:18 58:20 78:5 80:24 91:20 108:16 113:15 114:4 129:18,20 132:16 133:5,6 140:8 145:3 155:20 185:5 commented 117:17 commenting 113:7 114:10 157:22 158:5 comments 9:1,5,12 9:13,15,24 56:14 57:4 72:17 75:2,9 79:9 97:3 101:19 101:19 105:1 117:15,19 132:21 132:23 166:3 committees 18:22 common 6:5 32:24 33:8 35:6 44:21 51:18,22 52:4,10 53:9 150:15 communicated 70:11 185:2 communicating 154:22	communication 15:5 155:6 156:5 comorbidities 29:23 34:21 comorbidity 35:1 compare 68:12 70:3 196:22 compared 26:5,6,8 68:10 75:15 comparison 23:8 compelled 162:10 competencies 24:19 compilation 55:14 101:6 compiled 103:19 Compiling 101:18 complained 14:4 82:8 169:18 complaint 6:24 10:1 13:3,11,20 15:3 77:3 complaints 142:15 complete 8:1,6 127:5,12 completed 104:19 completely 37:20 Compliance 13:12 complicated 48:11 68:20 114:2 116:21 121:24 122:18,19 complication 20:1 complications 35:3 116:19 149:8 168:4,5,7 component 24:12 24:13,15 25:18,23 31:15 40:5 43:7 components 24:12 compromised 149:12 176:2 compromising 24:5 conceded 63:10,12 concedes 200:20 concentration 178:19
---	--	---	--	--

concept 175:1 concepts 170:19 175:8 concern 14:11 16:15 17:2,9,21 43:2,6 75:12,13 75:18 89:21 90:1 concerned 89:6 concerns 14:1 42:11 conclusion 204:19 204:21 condition 19:8 122:19 conditions 18:17 19:9 34:21 36:13 207:23 conduct 7:21 8:2 22:18 confide 192:14 confident 110:22 confiding 192:12 confused 160:3 176:7 confusing 30:15 connected 116:4 connecting 52:13 consequence 183:2 consequences 23:10 185:20 208:16 consider 10:17,17 34:17 48:10 196:13,15 209:7 consideration 21:6 48:13 147:16 considered 29:2 126:8,14,16 considering 121:23 189:12 consistency 185:20 185:23 consistent 33:12 167:15 consistently 42:6 consisting 210:7	constant 38:17 constantly 163:4 consult 19:12,17 consulted 194:24 contains 127:17,23 contemporaneou... 102:5 contention 66:10 189:13 contested 196:12 continually 132:9 145:7,20 Continue 185:22 continued 55:6 100:6 156:18 190:10 contract 209:1,4 contraindications 29:1 control 175:23 176:6 177:13 180:20 conversation 16:5 16:8 20:2 71:20 72:11 172:14 203:3 conversations 202:22 204:16 205:14,17,24 COOK 211:2 coordinates 47:2 47:10 copy 7:3 127:4,9 core 18:10 24:18 54:10 62:18 correct 12:14 13:19 31:4 51:20 52:8 63:18 109:14 119:2,14 130:11 131:18 137:4,13 143:16 145:14 152:22 161:2 175:20 177:22 181:3 210:9 211:10 corrected 145:7	165:10 197:10 correcting 153:14 168:4 correction 145:10 197:11 198:1,5 correctly 175:2,4 181:16 correlated 24:4 correlation 23:22 counseling 185:24 186:3 counselor 68:7 189:16,17 Count 13:5 counter 137:3 countered 17:12 COUNTY 211:2 couple 13:4 14:14 16:13,13 38:11 43:12 71:2 157:9 159:2 161:16 162:23 166:4 course 6:2 16:14 28:4 33:19 34:7 35:6 36:13 37:5 37:13,21 42:11,21 50:22 72:15 145:2 170:20 184:19,23 185:1 186:4 188:11 195:8 196:1,4 courses 24:21,23 25:4 42:3 207:22 court 1:1 4:10 5:6 5:11 210:1 211:6 COURTHEOUX 2:11 Courts 1:15 covered 118:16 168:10 CO2 172:12 create 176:24 200:12 206:10,20 206:22 created 123:12 creating 77:20	credit 181:7,16 credits 207:21 crib 94:9 114:19 115:16,17 116:7 criteria 172:17 critical 18:16,17 44:14 54:21 62:20 71:18 80:20 84:15 85:3 88:1,21 192:6 criticism 64:11,16 66:20 67:13,24 68:1 70:7 76:17 152:10 criticisms 63:1,17 64:7,23 67:20 116:17 criticize 79:12,24 83:9 criticized 68:6 95:5 criticizing 118:7 CRNA 12:11,15,19 22:14,16,17 26:10 37:16,19 38:3,21 39:10 42:17 44:7 46:11,11,17,20 49:16 50:11 57:16 58:17 59:6 60:11 63:23 64:11,22 65:13 66:11,13 74:17 76:16,19 77:1,3,9,16,20 78:6 79:22 80:17 80:20 81:3 82:5,8 82:12,15 83:3,6 91:16 93:19 95:8 107:18 116:21 126:11,15 149:20 153:1 154:22 155:2,10,16,16,17 155:17 157:3 170:11 175:3,6 201:17,20,22 CRNAs 8:13 23:9 23:14 25:12 37:12 37:14 41:12 43:9	43:10 45:9,19 47:10,16,20 48:18 48:23 49:7,11 54:1,11 61:19 62:19 63:3,9 67:13 70:11,19 71:17 72:6,14,24 73:15,17 74:7 75:1,8 76:1,13,24 77:13 78:2,3,12 79:11,15 80:13 81:14 82:18,21,23 83:8 86:13 92:6 112:1 135:9 155:7 156:2 187:22 191:9 196:23 CRNA's 66:20 67:2 cross 184:7 crossed 184:4 crucial 142:24 CSR 1:16,23 211:5 current 20:21 72:17 194:3 curt 139:24 cut 151:3 cutoff 169:15 CVO 159:23 160:1 160:15 <hr/> D <hr/> D 3:1 daily 68:12 danger 191:8,12 dangerous 183:6 data 150:5 152:16 153:14,15 date 56:21 57:9 58:8 123:18,22,23 124:2,6,14,15,24 125:8 168:23 192:9,15 dated 57:12,20 58:13 59:2,12,23 60:21 61:16 157:1 163:15 168:18 183:22
--	--	---	--	--

dates 41:9 59:18 192:14	degenerative 12:23	device 52:20	47:12 56:2 157:23	186:2
date's 192:13	degree 22:13 182:17 183:4	devise 33:16	182:13	discussed 67:23 98:16 108:11
DAVID 2:15	delay 195:17	diagnosing 37:8	directed 9:12,12,14 22:1 116:17 190:4	143:19 146:20
day 33:18 47:6 56:11,15 74:19 82:14 84:5,6,7 85:1,1,3,6 87:7 95:14 105:9,10,19 111:9 125:11 129:23 130:2 135:11 141:5,13 142:24 146:9 163:6,24 164:2 170:17,18 179:15 179:24 181:2,9 183:9 185:15 192:17,18 210:18	delays 166:12	didactic 24:12,15 24:24 25:2,4,7,15 25:24 26:10,21 30:2 31:16 32:12 32:20 36:17,20 168:13	direction 132:8 162:21	150:22 159:3 170:20 177:17 185:19,24 186:7 186:11 188:18
days 25:5,8 31:21 63:10 87:9 105:15 112:15	deleted 126:16	didactics 25:19 27:20	directly 9:18 10:24 121:18 131:14 156:13	discussing 108:3 141:24 177:11
deal 94:3,14 117:21 200:19 205:7	delicate 159:24 160:4	difference 131:20	director 13:12	discussion 4:23 17:16 154:3 172:5 172:10 180:4 186:18 208:3 209:13
Dean 195:1	delivered 112:15	different 8:21 22:14 29:21 31:16 31:19 32:11 34:6 34:6 36:17 48:5,7 48:22 49:7,12 53:16 66:12 67:5 73:12 75:20 78:4 78:11 85:6 88:24 90:19 106:23 112:4,8,23 113:3 127:11 134:11 135:18 140:17 142:16 146:8 147:5 158:10 167:13 173:8 176:3,16 177:9 179:17 181:13 187:22 193:1 201:7 203:2	disagree 152:12 154:8	disease 34:23
death 22:18,23 23:10,24	deposition 1:12 4:11,15,24 6:8 55:5,8,12 85:9 100:5,8 103:20 156:17 183:16 190:9,13,17 209:19 210:7,9 211:8	disagreeing 139:5	disagreed 66:19 109:24 115:19 118:18 150:7,8 152:10,13	dismissal 100:20 191:8,12
December 195:14	depress 173:21	disagreement 67:1	discern 108:14	dismissed 72:20 95:16 100:20 141:9 189:2 194:4
decide 21:3,9 187:24 188:12	depth 118:5,8,11 118:21	disclosed 15:14 191:14	disconnected 94:15	dismissing 196:3
decided 90:11 115:22,23 138:5 193:15	derogatory 9:5 10:5 12:12,16,19	disconnecting 114:11	discreet 71:3	disorganized 157:17,21 158:5
decision 36:5 39:24 40:1	described 95:7	discriminate 14:11	discretely 93:4,10	disparaging 80:16 80:16
decisions 21:7 35:7 35:19 37:8 114:1 116:21 197:10	describes 185:11	discriminated 14:11	discriminating 154:7	disparate 14:5
defend 197:9 198:4 198:8 199:23	describing 11:2 201:15	discrimination 7:9 7:17 13:21 14:1 15:7 16:21 17:18 18:1 54:11 73:17 75:12,13 209:6	discriminatory 7:22 8:2,8 13:11 14:5,20 15:15,22 16:10 76:12 77:21 153:2	disparately 75:14
defendant 2:12 86:13	description 90:14	differs 172:11	discuss 31:23 61:22 118:1 120:4 132:12 166:5,14 166:19 167:11,14	disputed 179:9 186:8 189:11
defendants 1:10,13 4:9 6:13 7:16 85:14	deserve 45:17	difficult 23:17,20 23:23 142:1 178:23 200:21		disregarded 77:4
defensive 68:4	deserved 183:7,13	difficulties 110:21 111:2 118:17		distracted 143:12
defensiveness 68:1	desk 134:11	difficulty 65:23 67:15,24 86:9 170:19 175:19		distress 87:17
	despite 189:13 196:16	direct 6:17 20:14		District 1:1,1,15 210:1,2
	detail 75:3,6 185:17			DIVISION 1:2 210:3
	details 58:24 80:18 143:18 177:21 185:14 186:16 205:2,8			DL 151:4,18 158:9 158:12,20 163:1
	determine 64:13 78:7 170:6			doctor 21:18 67:18 67:24
	development 39:13			doctors 18:18 20:12,14 21:3 22:1 68:7
	develops 130:9			document 6:21 85:11 103:14,20

104:17 111:11,13 120:6 129:10 133:14,15,19 186:22 187:2 206:10,13 207:2 documentation 196:20,22 documents 12:3,6 63:7 134:21 190:17,20 206:6 206:20,22 207:7 doing 5:11 39:6 67:16 100:14 121:1 126:23 128:9 138:22 147:3 155:13 158:2,2,17 159:9 159:15 171:10 186:14 197:11 203:14,18 211:6 donned 76:7 dosage 29:19 31:7 54:2 63:13,13 131:13 136:1 dosages 27:2,9 29:17 31:4 53:18 dose 30:24 120:12 120:23 133:2 140:9 161:10 dosed 132:24 136:8 136:22 doses 30:15 53:19 134:23 138:13 dosing 30:23 130:10,11,16,21 130:24 131:1,1,8 131:16,19 132:8 132:18 133:10,11 135:2,3,7,12 136:18,20 137:23 138:8,15 139:3 140:12 143:24 144:12 146:1,3 161:7 double-check 162:11	double-checking 162:4 down/chart 151:24 dozens 36:5,8 Dr 1:7 10:7,16 14:3 14:6 15:3,5,21 16:9,16,17,17,22 17:12 18:1,2 25:12,13 38:10 40:6,16,17 43:12 43:21 72:5,5,12 73:16,18 77:5,5 81:7 86:5,12,17 94:23 123:2 124:22 125:2 126:20,22 127:1 127:14 135:17,20 135:21 140:13 141:23,24 142:7 142:11 143:20 178:17,22 179:9 188:6,7,9,9,10,11 188:16,17,20 189:20 190:4,5 194:21,24 195:15 196:22 202:10 203:5,5 208:24,24 dramatically 36:1 draw 21:21 120:11 121:4 drawn 53:10,12 135:15 drew 120:22 drop 149:18,24 150:14 152:8 dropping 21:16 drops 159:18 drug 28:21 29:3,11 31:5 53:12,15,20 54:1 63:13 131:23 136:20 139:1 143:24 157:11 161:10 166:7 183:3 drugs 26:22 27:8 27:11,17,22,24	28:6,13,24 29:12 29:21,22 30:10,17 30:24 33:17 53:10 129:2,3,13,16,20 133:7,10 134:23 135:3,10,12,15,18 135:22 136:8,10 136:14,22 137:16 140:10 145:16,18 157:12 168:7 drug's 29:5,7 due 191:8,12 duly 6:14 duration 29:9,11 30:11 duress 195:4 Dwight 80:4,12,12 80:15,19,22 81:2 E E 3:1 109:21 ear 71:4 earlier 22:24 26:17 101:10 114:8 early 129:7 ease 202:1 easier 45:9 104:9 120:13 easily 202:7 EASTERN 1:2 210:3 Ebele 69:8 96:10 141:11 Ed 170:7 education 67:12 educators 182:10 effect 29:10 effectively 22:11 178:12 181:20 196:17 efficient 22:8 effort 48:10,16 83:9 173:21 efforts 157:12 egregiously 183:6 either 46:11 81:2	104:23 106:24 120:18 175:10,14 elaborate 77:11 elaborated 131:7 Elaine 2:3,5 204:8 element 23:13 36:21,24 175:3 Elizabeth 109:3 Ellis 73:6 75:7,7 126:20,23 127:4 Ellis's 127:17,20 email 156:24 200:13 emailed 43:14,17 embarrassed 143:9 embarrassment 143:15 embolism 89:1 emergency 23:3 27:11,17 131:23 135:3,12 136:14 emergent 33:19 112:18 116:16 employed 100:21 employing 156:9 enable 19:21 encounter 124:20 encounters 87:14 93:19 97:14 105:20 154:20 encourage 132:4,7 ended 88:12 147:2 147:11 endoscopy 41:6 enforce 18:23 22:11 enforced 10:7 engage 122:9,21 engaged 22:22 50:7 51:5 enrolled 9:4,20 18:4 101:1 102:1 enrolling 22:6 ENT 47:23 enter 39:17,19 entered 39:16	entirely 54:14 108:5,5 110:11 131:18 entitled 85:13 enumerated 7:20 86:2 109:19 164:14 Epalamine 88:13 88:16 equipment 110:7 116:18 178:4,5 ER 200:20 Erin 1:16,23 211:5 errands 121:17 erroneous 130:23 174:19 erroneously 174:13 error 131:5 esophageal 165:16 esophagus 165:18 ET 112:4,6 133:7 147:5,12,13,17,18 172:12 176:12,17 176:21 ETT 110:8,18 111:4,8,19 112:22 113:5,9,15,20 118:5,8,10,21 128:24 129:13,19 132:8,12,18 133:6 146:12 147:3,8,21 147:23 165:14 172:12 175:15,16 175:18 Eva 60:21 71:3,7 71:21,24 81:17 82:4,22 83:6 86:14 89:24 90:1 92:18,19,23 93:6 93:12,23 94:24 95:7,18 109:4,5 123:2 124:15 133:3 138:1 145:24 154:20,23 155:4 191:10 200:20 201:3
---	---	--	---	---

eval 41:8 69:4,5 76:5 80:16 84:21 88:19 89:10 94:22 evals 40:8 69:10 178:18 186:6 196:16 207:16 evaluate 25:14 44:9 70:15 79:3 80:14 155:8,21 evaluated 25:11 43:8,10,22 44:5 62:12 86:20 87:6 92:7 104:12 105:16 168:23 187:18 evaluating 45:20 46:20 78:18 87:12 121:21 evaluation 25:23 26:10 41:14 42:17 43:20 46:7,13 55:14 56:20 58:10 59:10,23 60:15,20 62:8 71:8,11,23 74:20 76:8 80:20 82:12 85:3,5 87:10,20 88:1,4 89:2 90:2,22 94:12 101:15 102:10,16 103:1,5 103:6,14,15 104:6 104:19,22 105:4,9 105:12 106:8,13 106:16,20 107:3 107:10,12,13,16 107:18,24 108:6 108:21 109:6,7,12 109:24 110:6 116:9 117:19 119:15,17 120:2 123:6,8,12,15 125:17,21,24 126:3,7,10,11,16 127:7,14,17,19,22 127:23 128:2,6 132:2 145:6 148:4	148:6,11,24 149:3 149:4 150:18 153:1,16 157:3 163:14 164:7,14 164:17 165:12 166:4 167:1,2 168:15 170:11 185:10 186:15 191:24 192:8 evaluations 8:12,16 14:10 16:14 25:17 26:6,15 41:12,16 41:21 43:4 45:2 54:12,13,21 62:20 63:9 64:23 66:11 68:19 69:12,16 71:19 81:15,16 84:8 86:8 95:15 101:6 104:2 127:2 127:5,12 178:16 179:4,5,6 184:12 184:16 185:6,9,16 186:9,14 187:10 189:11 191:9,13 196:12,24 207:8 207:13 208:5,15 209:7 evaluative 46:15 101:19,19 106:24 128:19 evaluator 109:20 Eva's 146:2 event 123:15 141:1 141:10,11 150:6 157:11 events 19:15 23:3 141:13,16 142:24 evidence 72:12 135:5,24 136:4 evident 193:16 evolved 37:5 exact 11:9,20 58:24 75:3,5 80:18 111:20 141:16 185:14,17 206:17 exactly 11:15 35:12	64:13 70:18 87:22 111:10 118:19 119:11,13 141:20 162:8 163:3 177:21 examination 1:13 3:8 6:17 93:24 examined 6:14 129:8 132:15 examining 93:2 141:24 example 130:19 examples 35:5 101:18 exceed 42:6 exchange 140:20 excision 113:1 117:3 excuse 145:23 146:4 excuses 132:9 145:8,20 exercise 36:12,24 37:12 exhibit 6:8,21 55:8 55:12,12 58:8 62:16 85:8,9,11 85:19 100:8 101:5 101:6 102:11 103:17 109:15,17 110:17 112:10 126:2 148:7 156:20 170:14 183:16,19 187:3 190:13,16 exhibits 3:14 55:1 exists 52:14 expand 176:2 expect 33:3 34:11 expectation 54:8 expectations 32:10 32:15 expected 30:9 32:19 60:7 107:1 143:23 164:19 165:13	expecting 35:24 expelled 73:21 178:17 experience 18:12 22:22 23:9 33:9 33:23 46:1,2 72:19 80:17 96:6 122:5 132:24 139:9 197:20,21 experienced 8:23 46:3 51:9 experiences 40:11 76:2 79:17,20 106:2 146:7 experiencing 189:24 198:22 expiratory 94:4 explain 51:20,20 86:24 139:21 145:21 157:16 197:9 explained 12:4 139:14,20 189:20 199:20 explaining 169:16 199:9 explanation 109:23 116:12 146:4 148:15 explanations 169:14 explore 113:2 exposed 122:16 195:18 exposure 32:14 48:5 expressed 86:9 198:19 extensive 117:4 extent 24:2 extreme 178:15 179:10 extubated 173:7,13 extubation 114:5 eyes 128:10	F F 7:20 130:8 fabricated 54:11 62:19,24 128:3,20 fact 94:13 103:5 facts 66:23 72:13 153:18 faculty 61:13 fail 179:13 failed 186:6 189:10 197:4 failing 42:20,23 187:4 194:3,16 196:3,16 failure 42:11 209:10 fair 21:23 25:18,20 25:21 26:13,14,20 30:12 45:17 56:9 56:12,18 57:5,16 57:24 58:17 59:16 59:20 60:10,15 61:5,21 62:3,8 65:1,10,17 77:8 79:1,5,7,8 90:11 105:5,8,9 107:5 108:1,6,13,15 118:8 153:20 163:23 167:2 168:24 169:2 197:3 fairly 53:5 fairness 108:16 fall 168:10 170:20 195:12 false 8:12,16 14:9 54:13 62:24 126:7 128:3 130:17 142:13 149:14 155:15 falsehoods 126:13 falsely 123:22 falsified 54:12 62:19 familiar 27:18 31:5
--	--	---	---	--

53:5 far 8:5 47:9,15 86:23 139:19 163:4 168:12 207:8,13 faulted 149:20 favorable 44:16 February 1:18 41:7 58:13 59:2,12 210:7 211:9 Federal 4:10,12 feedback 38:24 43:14,20 47:14 119:13,15 feel 14:4 22:22 70:2 128:11 200:1 feeling 68:13 143:9 feels 73:17 75:14 felt 14:11,23 15:15 15:17 23:19 24:3 25:19 45:16,17 66:22 74:9 77:7 80:6,24 89:19 96:11 105:10 142:22 143:6,7,18 162:10 169:5,7 181:14 195:9 female 170:23 fentanyl 28:4 130:24 131:1,10 138:7,8 142:2 173:20 figure 118:5 176:4 figured 135:2,7 136:1 figuring 132:8 file 127:17,20 Filipino 15:1 98:3 filled 41:8 105:7 123:15,16 124:7 124:16 137:14 final 184:22 194:10 find 58:5 107:16 109:6 125:24 128:18 142:1,6 148:11 167:1	210:8 fine 4:22 129:9 141:18 finish 5:2 24:23 finished 140:3 173:17 first 4:21 6:13 7:7 13:24 14:7 38:2 56:3 85:14 101:14 102:14,15,21 103:9,11,13,20 110:21 111:1 112:23 117:2,11 117:13,17 118:14 118:15 120:20,20 120:24 122:14 125:17 126:6 127:23 128:7 130:2 135:6 137:14,22 147:16 148:24 149:11 157:9 165:14 171:3 182:15 190:22,24 201:16 207:18 208:6 Fisher 60:21 71:7 71:11,21,24 81:17 82:4,22 83:6 86:14 89:24 90:1 92:19,23 93:23 94:24 95:7,18 109:3,5,21 114:10 115:19 123:2,6,12 124:15 133:3 145:24 154:23 five 31:20 79:9 105:20 106:1 179:4 186:16 187:19,22 195:14 196:9 five-month 100:16 fixing 199:3 flagrantly 126:7 flexible 202:7 fluid 117:4 fluids 21:17 116:15	116:21 fluoroscopy 38:18 focus 7:17 151:2 focused 100:18 Fojolli 73:6 76:21 76:22,23 77:18 follow 21:21 33:21 83:8 111:23 174:15 followed 34:1,10 70:11 94:22 110:15 111:12 following 93:18 119:1 175:18 191:24 follows 6:14 55:7 100:7 109:23 156:19 190:11 193:6 follow-up 31:22 force 157:24 foregoing 210:6 211:9 foreign 165:18 Forester 82:16 86:15 87:23 93:7 Forgetting 192:14 forgive 51:19 forgot 22:24 32:3 forgotten 166:15 form 84:16 106:23 124:7,16 165:9 183:21 184:9,12 184:19 former 72:17 forms 55:14 209:5 forward 96:10 140:9 found 162:3 four 49:24 61:10 179:4 fours 181:24 fourth 83:21 84:5 frequency 86:9 frequent 41:12 45:23 86:6 87:3	88:22 frequently 180:7 friends 191:10 front 93:21 109:16 110:3 141:3,4 143:9 148:7 full 83:19 90:5 105:19 126:12 127:4,11 156:12 201:19 207:21 functionality 176:5 further 116:9 139:13 198:23 fuzzy 158:16 <hr/> G <hr/> G 2:11 Gardner 73:7 78:1 gases 150:16 173:20 174:6 gatekeepers 78:6 78:13 gauge 93:8,9 98:21 161:22,24 gauging 162:22 197:19 Gawura 59:10,23 60:11 86:14 90:4 90:7,10,15 92:1 168:15,24 170:11 170:17 177:8 179:2,22 183:8 186:23 187:16,19 192:7,13,15 Gawura's 181:1 general 88:12,14 100:23 118:3 146:16 161:15 165:17 169:16 171:11 generally 18:13 27:4 49:21 51:8 134:21 gesture 122:11 getting 45:5 75:24 81:7 151:2 169:18	178:16 181:4,14 181:18 195:5 196:1 200:3 gist 21:2 81:5 give 19:14 46:13 81:16 119:12 127:8 140:7 160:5 169:8 181:21 183:24 194:17 195:1 given 8:12,16 27:17 27:22 169:20 171:18 173:2 174:9 194:8,13 195:6,11 197:23 210:9 211:8 gives 34:11 181:24 giving 53:20 88:1 158:22 183:3 196:4 GlideScope 150:22 150:23 151:2 154:3 158:3,7,11 158:18,19 gloves 76:6,17 glyco 28:15 glycopyrrolate 28:3 go 4:18 9:24 21:17 35:16 58:4 75:17 108:20 125:16 126:22 139:13,24 146:9 147:19 148:6 162:15 181:7,10 200:14 200:15 207:19 208:7 goal 22:6,7 48:21 49:4 189:15 goes 35:17 125:20 157:16 161:14 174:24 180:2 going 15:24 39:21 54:24 55:21 61:7 65:2 70:20 78:5,9 87:17 96:10
--	--	--	---	---

107:13 122:24 129:16 137:18 138:12 140:13 146:21 153:9 156:3 166:6 178:23 179:2 180:11 182:9 188:5,18,22 189:7 195:1,10,17 204:8 204:14 good 4:2 56:15 143:20 Gosh 28:15 gotten 45:1 59:1 72:16 grab 158:8 171:8 grabbed 158:15,16 gracious 45:18 grade 79:3 128:12 169:8 184:23 185:22 194:8,9,10 194:15,16 195:2 196:1,10 graded 25:19 26:7 42:3 74:3,3 169:6 169:10 194:23 grader 169:10 graders 45:9 grading 45:18,20 45:24 79:2 169:12 196:2,14 graduate 183:3 graduating 188:15 graduation 126:24 grasp 173:3 great 104:8 162:2 163:20 grilled 74:9 grilling 15:17 ground 4:18 grounds 42:11 group 55:12 73:3 78:3 86:13 96:17 103:17 121:3 guarantee 209:10 guess 11:10 22:11	26:6 27:16 32:1 35:22 45:13 47:3 47:21,23 48:6 66:5,18 76:4 77:4 81:20 95:15 108:14 111:17 123:16 124:3 161:21,23 165:8 174:2 180:19 194:24 195:23 198:2 199:24 205:11 guessing 124:4 guidance 179:2 182:8 guide 27:12,14 34:5 34:10,13 35:10,23 35:24 110:12,12 111:24 205:8 guidelines 21:21 guides 31:3 GuideScope 163:2 guy 170:3,8 guys 170:6 H habit 157:24 171:11 habitually 171:12 hair 189:22 Hakeem 73:5 96:11 126:20 127:8,9,13 half 194:3 halfway 199:2 hand 6:20 55:11 87:9 91:10 101:5 123:14 161:15,15 172:20 173:3,15 174:7 181:12 handed 190:15 handle 48:12 151:4 158:9,21 199:21 handled 93:16 handling 199:9 hands 32:14 162:18 handwriting	143:21 144:11 145:6 150:21 151:21 184:11 handwritten 110:7 117:18 132:2 191:15 happen 23:5 33:3 34:24 35:21 46:1 66:23 71:8 106:3 136:11 146:15 158:24 160:1 165:1,4 171:7 172:21 183:11 189:8 207:24 happened 8:22 46:9 71:6 74:15 76:10 79:13 87:16 93:3 95:17 99:24 114:13 119:23 123:16 133:18 140:14 141:12,16 149:23 151:13 153:19 154:1,4 163:7 166:9,20 179:16 184:5 happening 72:10 72:16 78:16 141:18 happy 195:16 harassed 8:12 80:9 141:2 harassing 7:22 8:3 8:9 harassment 7:9,18 13:21 15:2 80:6 hard 59:3 119:20 170:6 harder 86:6 87:2 88:21 harshly 74:10 87:2 96:12 hates 96:19 head 93:5 172:20 173:3,15 174:3,13 174:16 191:23 health 24:5 188:4	189:19 healthy 170:22 hear 9:11 45:4,8 91:15 189:23 heard 9:13 45:7,10 155:20 hearing 155:1 heart 27:9,13,19,22 28:14 30:10,18,21 heavier 169:20 height 121:2 heightened 36:24 held 91:11 183:4 help 52:24 90:11 132:4,7 176:17 180:19 182:11 205:2 hemodynamic 150:17 hemotherapy 117:5 Herculean 178:21 187:8 hernia 137:10 hesitancy 60:14 hesitated 206:2 hidden 203:18 high 23:17 higher 32:16 128:16 highlight 19:23 20:22 Hilarie 190:23 hindrance 10:8 history 19:22 29:2 33:16 hold 115:22 holding 181:12 holidays 188:14 home 84:4 hook 52:16 Hooker 57:8,17,20 107:14,14,19 148:9,17 149:1 153:2 154:22 155:3,17 156:4,24 157:20 162:7	179:8 187:15 Hooker's 157:3 Horey 170:6 hospital 100:18,23 129:7 hour 1:19 hours 129:7 137:17 169:21 humiliated 74:10 143:9 Huntzinger 15:13 15:16 97:15 141:4 141:4 HUSCH 2:8 hypertensive 152:24 I iatrogenic 116:19 ICU 18:5,9,11,13 19:3,17 20:15 21:10,13,24 22:14 22:21 23:6,8 37:23 53:3 100:12 100:18,21 114:22 idea 83:11,12 98:12 147:2 159:10 identification 6:9 55:9 85:10 100:9 183:17 190:14 identified 63:4 79:19 identify 79:3 identifying 159:4 ignore 126:10 Illinois 1:1,18 2:4,9 210:2 211:1 imagine 182:16 185:15 immediate 149:21 immediately 16:12 134:1 171:5 impacted 8:18 142:20 impedance 10:22 11:22
--	---	---	---	--

impede 6:6	incorrect 85:4	informatics 18:22	interacted 20:5	157:17 161:14
imperfections	111:18 128:23	information 37:5	99:19	173:9
182:11	129:22 130:10,20	46:15 68:16 69:23	interaction 14:23	intubations 171:12
implicating 71:5	131:16 144:12,13	71:24 97:22	124:23 169:13,16	invasive 147:20
importance 166:5	incorrectly 51:21	130:18 141:7	198:13 200:23	investigate 196:18
167:17,20 168:1	increase 177:15	142:21 143:13	201:3,7	investigation 75:11
important 23:13,24	increasing 177:16	151:24 192:24	interactions 21:2	75:18
23:24 49:11	independent 21:12	informed 129:11	143:3	involve 25:3
143:19 167:17	21:14 37:20	135:19 186:20	interchangeable	involved 112:14
imposed 194:20	independently 22:9	203:15	174:18	118:16 121:19
impossible 178:23	22:13	infractions 81:5	interference 47:4	126:9 135:18
impression 10:20	indicate 104:11	inguinal 137:10	74:14	146:18 155:6
72:9 155:11,15,16	118:9 120:11	inhaled 119:6	interjected 93:12	161:13 175:18
188:20 202:4	125:4 126:7	120:8	188:11	178:13
impressions 74:2	149:11 173:6	initial 177:6 191:1	internal 75:10,18	involves 22:18
impressive 28:18	189:9 191:1	initially 38:3 115:9	internalizing	52:13
improper 155:5,9	indicated 60:6	157:23 158:17	198:11	involving 26:22
improve 104:10	77:24 120:21	188:7 192:12	interpret 80:13	67:2 79:22
198:12	174:2,14 180:5	initiated 4:10	interpreted 11:24	iPhone 203:17,18
improved 150:10	indicates 8:11	input 21:4 137:21	76:7 187:9	irregularity 158:13
152:21 177:23	13:10,15 56:14	inputting 138:5	interpreting 117:6	issue 15:10 16:22
improvement	60:7 105:12 123:5	inside 134:10	117:10	18:1 33:20 75:20
183:21 184:9,12	125:21 145:6	insomniac 189:21	interrogatories	77:6 94:3 109:13
inaccurate 59:7	165:14,22 172:23	instabilities 150:17	85:15,18 109:17	110:18 128:19,19
inadequate 149:13	173:10 185:9,18	150:17	interrogatory	144:19 151:11
inadvertent 163:1	191:23	instance 88:10	112:10 116:13	165:19
inappropriate	indicating 80:13	126:15 165:7	120:17 123:5,9	issues 37:8 63:13
88:19 91:22 92:2	85:22 117:20	178:14	125:3 126:1	63:17 64:8,10
92:24 94:1,11	122:23	instances 63:12,21	148:15,20,22	66:3,12 67:2 76:5
95:1,6,9	indication 154:21	71:2 75:22 81:6	149:10 164:12	92:17 144:13,16
inasmuch 197:3	165:9 174:23	90:19 95:12	165:6,21,22	185:11,13 186:2
incident 77:7	individual 1:7,8,8	178:12	interrupt 142:14	i.e 161:18 185:22
178:11	7:16	instinctively 175:21	intervene 209:6	
incidents 200:19	individually 4:9	instruct 171:5	intimated 75:6	J
include 37:7 50:1	individuals 7:2	instructed 167:8	77:22	J 104:11
52:7 137:15	induction 28:7	instruction 146:8	intraoperative	Jackson 2:3
202:21	119:6 120:9 135:3	198:7	149:7	January 59:24
included 64:8	157:12 171:2	instructors 182:11	intravascular	105:19
71:24 86:13	infant 112:14 114:3	instrument 64:10	150:16	jeopardizes 126:24
102:21 179:8	117:8	64:16	intubate 118:3	Jill 1:8 15:2,12 70:7
includes 103:6	influence 75:4	instruments 52:8	158:22 160:6,19	71:2,20,23 74:18
105:1 109:7	influenced 85:5	insurmountable	intubated 144:18	74:20 80:9 81:6
184:20	155:4,7	23:21	144:23 173:11	81:10,15 82:3,6,8
including 139:23	influencing 155:9	intended 86:24	intubating 91:9	82:21 83:3,8,17
175:7	inform 200:22	intention 188:3	145:1	84:9 85:3 92:14
inclusive 210:8	201:2	interact 19:2 20:8	intubation 151:5	95:4,24 96:14

97:2,5,8,10,14,23 104:12,19 105:4 105:16,22 106:9 123:8 124:20 125:21 140:21 154:20,22 155:20 191:9 200:20 201:3 Jillian 163:14 164:3 Jim 43:19 job 47:1 104:8 163:20 182:13 Johnson 194:24 203:5 208:24 JOSEPH 2:16 journal 31:22 judging 154:18 judgment 21:12,15 36:12,21,23,24 37:12,20 66:12 67:2 75:4 116:10 117:7 130:8 153:18 154:12 156:9,11 159:22 178:8 185:8 judgments 66:19 154:8 155:21 Judy 12:22 44:5 56:4 106:17,20 164:7 187:15 July 86:18,20 102:16,21 103:6 142:12 148:8 149:1,2,2 157:1 163:15 164:9 168:18 170:10 179:3,15 183:22 184:16 185:13,19 186:21 187:19 191:1,3 192:15,19 June 38:10 71:14 71:15 74:22 83:4 92:15 95:5 96:1 107:13 108:21 109:20 119:18	123:7,13,21,23 124:6,14 125:5,18 185:6,7,10 justified 137:24 K Kam 14:24 16:6,9 73:5 74:6 Karen 2:11 14:24 15:11,14,17,18,20 16:6,9 73:5 74:6 74:24 97:12,17,20 98:1,15 141:3,12 141:15 karen.courtheou... 2:10 Kathy 96:19 97:1 Katie 61:19 62:11 Katsionis 40:17 Kazim 73:6 Keehn 86:14,20 87:5,11,20 keep 4:19 73:22 109:15 199:14 keeping 37:8 kept 81:7 94:23 127:4 kid 93:8,13 kilo 138:9 kilograms 136:9 137:9 Kim 15:13,16 97:11 97:15,20 141:4,4 kind 19:14 24:11 29:3 37:17 53:23 77:16 78:17 93:20 160:23 174:24 kinds 48:5 68:18 Klunk 163:15 164:3 knew 41:24 42:14 65:23 66:3 72:9 141:11 196:17 knock 91:12 know 5:14,23 9:23 17:4,6,8,21 20:21	21:18 27:4,9,12 27:19,20,22 28:14 28:18 29:13,13 30:8,9,17,21 32:14 34:7 39:23 39:24 41:3,8 42:5 42:9 44:21,24 45:2,12 47:1,5,7,9 47:15,16,18 48:9 48:14,16,20 49:1 49:2,10,13 51:10 52:23 53:20 59:18 61:18 62:2,8 63:8 66:8 67:7 68:9,23 69:17,24 70:1,23 71:13 72:16 73:14 73:19,22,24 75:5 75:19 76:9 77:16 81:9,12,13 83:2,9 86:17 89:1 96:19 97:9 98:2 99:6,8 99:13,17,20,21,24 100:3,3 111:7,8 111:15,18,19 113:4,8,14 118:4 119:2 120:20,22 122:7,7 124:24 126:8,15,19 127:6 127:16,19 128:8 130:11 133:18 136:14,20 137:1 137:23 140:9,18 141:13 142:2,23 143:16,17 146:9 147:11 151:24 155:18 156:4 158:14,24 159:19 163:3 166:22 167:10,15,22 168:1,12 169:7 171:9 175:2,11 176:13 177:5 178:2,9 181:5 182:7 185:14 188:8,10 194:23 195:22 196:13	197:23 198:12 200:3 202:3 203:14,15 204:15 204:22 207:1,9 208:1 knowing 29:5 118:7 175:4 179:13 knowledge 32:20 60:12 65:23 107:6 121:2 164:1 175:6 204:21 knowledgeable 163:21 known 155:24 161:1 knows 134:6 Kramer 190:5 Kremer 1:7 10:7,11 10:16,23 14:3,6 14:18 15:3,5,21 16:9,16,17,22 17:12 18:1,2 25:12 43:12,21 72:5,12 73:16,18 86:5,12,17 94:23 124:22 126:20,22 127:1,6,14 140:13 141:23 143:20 157:1 178:17 183:24 184:15 185:13 188:9,10 188:16 189:20 194:21 196:22 202:10 203:5 207:14 208:24 Kremer's 81:7 125:2 K.B 2:3,5 L L 2:11 193:11 label 53:15,19 54:6 labeled 53:10,16 labeling 128:10 labs 21:21	Ladder 10:19 Lai 40:16 laid 136:3 Land 2:11 3:10 4:2 4:6,7,15,18,23 5:6 5:11,17,21 6:3,18 16:3 17:3 39:23 49:2 55:2,10 61:9 62:7 65:4,12 66:8 70:24 78:11 83:12 83:16 85:8 89:14 89:21 98:23 99:17 100:10 103:1,4 107:11 113:13 118:2 120:5,11 124:10,13 125:10 125:13,16 139:18 140:11 147:21 148:22 155:23 156:15 161:16 190:6,12 204:8,11 204:20 209:16,18 lane 152:3 language 105:2 lap 113:2 laryngoscope 163:1 laryngoscopy 157:24 lawsuit 4:10 7:3 lawyer 204:3 lay 138:12 Lea 82:16 84:17,19 85:4 86:14 87:23 93:7,19 lead 38:17,19 70:11 180:16 Leader 207:20 leading 17:19 86:19 102:4 leads 82:2,17 103:7 learn 28:20,21,23 53:2 67:13 182:12 198:5 learned 32:16,20 56:16 learning 26:22
---	---	---	--	---

146:7 182:9 193:19 leave 14:13,16,19 17:22 40:23 43:23 43:24 44:2 86:19 91:19 92:5 100:15 100:17,17 102:4,7 102:13,21 103:9 103:12 180:17 184:10 188:1,3,8 188:13,16,18,22 189:2,8,18 192:1 192:2,5 193:20 194:14,17,21 195:1,5,11 196:5 197:3 208:11 Lea's 85:5 lectures 25:13 93:8 led 72:24 199:3 left 15:16 38:11 46:11 74:11,13 77:2 100:11 112:10 134:8 188:23 leftover 160:6 leftovers 160:7 legal 1:22 204:15 204:18,20 length 139:24 lenient 196:3,7,11 197:2 letting 158:23 let's 4:18 6:20 21:15 22:3 31:8 44:12 98:1 117:18 125:16,24 148:6 156:15 level 60:7 107:1 142:20 143:14 164:18 165:13 202:5 lid 171:6 Lidocaine 28:8 life 22:18 23:10,24 life-saving 178:3,5 lift 172:20 173:3,15	174:14 lifting 174:16 limit 200:23 201:3 limited 32:6 202:15 line 132:3 137:6 152:18 154:11 lines 139:18 lining 89:19 140:16 list 7:21 8:1 27:8,19 27:22 28:1,10,13 29:12 30:17 107:13 listed 8:24 123:22 135:8 148:3,8 lists 13:5 136:8 little 18:3 22:3 30:13 44:12 49:23 76:4,17 93:20 134:8 139:13 143:8 158:16 169:5 171:18 176:7 201:18 206:2 LMA 146:11,12 147:2,4,7,13,15 147:17,20 148:3 170:22 171:14 172:11,12,18 173:7,10 175:2,4 175:14 176:8,20 176:22 LMAs 146:17,21 171:5 LOA 194:2 201:16 202:6 load 169:20 loads 47:6 long 18:7 24:15 29:14 79:7,8 142:15 155:17 180:3 196:5 202:21 longer 169:21 171:1 look 7:19 12:2 33:15 43:13 55:13	63:7 85:18 86:1 96:2 102:15 106:12 107:11 108:17 113:1 117:18 123:7 126:1 142:8 148:24 164:17 166:3 168:6 171:1 173:11 174:1 190:15 192:11 196:18 198:23 looked 136:6 141:21 142:11 166:22 187:11 looking 39:3 58:4 71:4 105:8 143:11 156:21 186:23 187:2 200:9 looks 45:3 57:3,8 57:15 144:10 151:21 152:1 157:6 163:14 183:21 191:18 192:20 193:22 198:24 losing 189:21,22 loss 171:6 lost 124:12 133:13 133:14 lot 33:11 49:7 76:1 89:7 99:19 126:13 145:17 161:20 186:13 197:24 loud 5:9 177:20 louder 165:8 loudly 93:12 lounge 124:21 125:1 lower 108:3 151:22 160:1 169:8,11 lowering 159:22 lungs 176:2 Lutheran 100:23 M machine 51:23 52:2	145:3 machines 178:13 MAGNA 1:22 Mahalia 80:3,5 81:3,4 main 24:11 43:11 189:15 maintain 23:20 major 147:10 majority 38:13 39:3,8 making 21:6 31:2 37:8 66:23 132:17 151:23 152:5 153:8 155:15 168:6 182:21 manage 178:2,9 managed 39:3 67:11 178:12 management 19:15 19:16 52:5 63:17 64:1,8 117:4 130:11 131:3 143:23 144:6,13 144:14,17,24 149:14 managing 21:22 122:1,24 145:2 152:14 161:24 170:22 178:19 Manahas 123:2 manner 197:12 marathon 5:22 March 56:20 57:8,9 57:12 Marcial 1:3,12 3:4 4:4 6:8,12 10:13 55:6,8,11 85:9 86:5 100:6,8 156:18 183:16 190:10,13 209:20 210:15 211:8 Maricel 1:3,12 3:4 4:4,22 6:12,20 10:16 145:7 156:20 161:17	162:2 164:22 165:15,16 172:17 180:5 183:19 190:15 210:15 211:8 mark 85:8 190:12 marked 3:14 6:9,20 7:6 55:9,11 61:2 85:10 100:9 101:5 109:16 183:17,18 190:14,16 Mary 56:22 mask 114:22 119:5 120:8 171:4,9,12 171:22 172:1,2 masking 171:6 mass 113:1 117:3 material 139:10 168:10 matriculated 18:10 matter 118:3 205:9 McLaughlin 1:16 1:23 211:5 mean 9:10 10:12 26:3,16 27:15 29:7 30:17,19 31:5 33:13 35:18 35:20,23 47:13 53:12 54:19 65:12 70:16 72:20 77:12 81:12,23 94:15 99:21 103:13 106:1 108:12,17 142:14 151:8 169:2 187:9 192:9 198:14 203:7,12 206:14 208:22 meaning 42:16 131:19 166:17 means 30:18 115:17 138:17,20 152:15 201:10 meant 5:18,22 100:11 105:21 117:24 119:12,20 120:3 130:21
--	---	---	---	---

134:22 159:12 171:24 184:16 measures 18:23 mechanism 29:11 medical 1:6 4:8 7:1 18:17 19:9 29:2 29:23 48:7 53:24 66:19 67:2 130:18 134:3 medication 6:5 161:19 medications 28:4,7 120:12,22 121:4 137:21 medicine 139:15,21 meet 42:6 47:22 meeting 11:3,16 17:17,20,22,24 184:17,24 186:9 186:11 187:6 188:17,23 192:20 193:23 199:11 202:11 203:1,9 208:23 209:14 meetings 14:3 16:15,16,21 17:1 17:8,8 47:14 155:2,6 member 61:14 memory 73:12 206:18 MENDELSON 2:16 mental 180:8,12 189:19 mention 22:24 75:2 129:6 172:23 mentioned 14:22 15:6 40:6,14 63:20 76:14 80:15 81:17 131:15 139:22 165:24 174:13 180:15 204:7 mentioning 68:7 174:20	mentor 192:11 merits 209:7 message 96:23 97:8 messages 205:16 met 124:22 140:18 185:15,18 191:23 Meyer 135:17 Meyers 135:20,21 mic 138:9 MICHAEL 1:7 middle 134:18 194:22 midway 195:2 Mike 157:1 183:24 184:15 185:13 201:2 202:9 207:14 Miller 43:19 milligrams 136:9 137:10 mind 4:19 15:3 178:24 179:11 180:19 182:7 189:16 195:9 Mine 192:24 minority 14:24 73:3,11 170:5 minute 36:1 98:1 123:8 172:20 173:16,23 174:7 miscalculation 64:2 mischaracterizes 65:3 155:22 161:5 mispronouncing 98:24 misrepresentations 126:12,21 misrepresented 54:14 153:11 167:24 misrepresenting 153:6 misspoke 16:1 mistakes 31:3 63:4 63:24 65:21 66:2 182:12,14,16,18	182:21 183:5 mistreated 15:12 77:13 mistreatment 13:12 14:20 mix 48:16 mixed 77:17 mixture 135:18,21 mode 175:20 176:3 176:8,19 177:4,9 modes 176:7 177:12 modify 37:17 moment 36:23 monitor 137:16 monitoring 38:5,22 39:2 46:17 64:10 64:16 month 59:2 188:9 188:12 195:12 201:16,22 monthly 155:6 months 194:3 195:14 201:20 morning 4:2 33:15 82:9 129:6 135:10 135:14 morphine 28:4 130:21,22 131:9 131:10,14,16,19 132:24 133:2,11 137:10,23 138:15 142:2 146:1,3 motioning 94:9 114:18 115:10 motivated 154:15 motives 78:21,23 124:2,3,5 motor 160:8 mouth 73:21 172:24 175:7 move 55:18 66:7 83:14 115:16,16 160:20 moved 30:5 46:6,16 116:7 134:11	movements 160:9 multiple 42:9 43:3 43:9 77:13 81:4 muscle 28:5,6,9 159:23 160:3,5,11 160:16,17,18,21 161:8,10,12 166:8 167:23 171:15 173:1,17,24 174:3 174:9,12,15 M-a-r-c-i-a-l 4:5 <hr/> N <hr/> N 3:1 name 4:3,3,4,21 28:21 40:18 54:1 111:15 190:3,22 named 4:9 7:2 61:14 names 77:15,16 Narbone 1:7 10:2,4 10:8,15 11:3,5,15 25:14 44:9 46:19 209:3 Narbone's 10:12,21 narrative 131:7 168:9 180:2 Nate 170:6 national 7:12 9:2,6 9:16 12:16,24 13:22 14:21 15:6 15:10 95:20 96:3 98:2,4 99:8 154:16 nausea 19:22 near 13:4 162:1 necessarily 85:1 89:9 111:23 112:2 121:23 197:23 206:17 207:3 necessary 171:6 neck 117:3 need 27:17 28:20 28:23 29:13,13 30:19 35:6,10 40:6 55:13 56:15	118:4 139:15,21 152:22 167:19 176:17 185:19 201:19 202:3,5,17 204:8 207:3 needed 27:8 28:14 28:21 37:4 52:22 119:13 121:18 143:17 145:1 150:8 151:12 164:21 172:17,19 173:15 182:8 187:5 needs 19:20 20:17 30:1 143:23 144:6 negative 8:12,16 10:6 12:16,20,23 14:9,10 16:14 40:7 71:18 74:19 76:2,8 80:17 81:6 81:16 82:11 84:21 85:3 86:8 94:22 117:15 127:14,17 127:19 155:20 170:11 178:15 179:5 186:5 187:10 189:11 191:24 192:7 196:12 negatively 94:12 negatives 178:18 178:21 187:8 189:10 196:16 neonatal 114:22 neostigmine 28:2 28:15 nervous 140:20 162:3,10 nervousness 141:6 142:20 neuro 47:23 never 39:16 67:23 98:22 99:19 117:17 134:13 new 19:1 54:24 83:3,6
---	---	--	--	--

newly 76:7 Nguyen 98:23 99:1 nicer 45:15 night 15:18 33:22 33:24 34:15 141:2 nodded 137:3 noise 199:15 nondepolarizing 166:8 nonmedication 137:18 nonminority 75:15 81:9 96:13 non-passing 184:22 normal 149:16 normally 158:1 182:14 NORTHERN 1:1 210:2 Notary 210:21 noted 177:1 notes 58:20 191:6 191:15 193:6,9,22 197:5 198:24 200:9,14 211:10 notice 1:13 4:11 noticeable 174:4 notification 184:23 November 60:21 195:13 203:8 NRS 185:22 number 6:21 48:1 55:12 101:6 104:17 109:17,19 159:4 172:6 183:19 184:20 190:16 193:4 numbered 104:18 numbers 31:6 58:3 193:1 numeric 58:7 107:22 nurse 10:13,19 18:5 18:9,13,14 19:3 19:17 20:15 21:10 21:13,24 22:9,14	22:21 23:6,7 37:24 50:14,15,18 53:3 100:12,22 133:16 134:2 207:20 nurse-driven 21:20 nursing 19:1 N-g-u-y-e-n 99:5 <hr/> O object 15:24 39:21 48:24 61:7 65:2 70:20 78:9 204:18 objection 61:8 65:9 66:6 100:2 117:23 161:5 Objections 85:14 objective 173:12 objectives 22:4 observation 40:14 81:21,23,24 82:2 151:20 197:17 observe 51:9,12 115:24 122:6,9,22 174:8 observed 70:17 71:11 72:1 116:6 151:19 153:23 observer 113:22 114:3 observing 141:18 obstruction 164:21 165:10 obviously 51:18 occasion 20:16 50:2 53:15 67:4 71:8 88:2 164:22 occasions 19:4,19 21:15 38:9 50:10 69:3,9 73:10 83:19 95:13 occur 20:1 occurred 154:19 occurrence 71:6 76:9 occurrences 36:3	occurring 11:3 October 61:16 195:13 200:10,15 208:2,9 offend 199:24 office 13:12 125:2 off-site 75:23 OGT 165:16 Oh 26:16 73:12 97:6 113:6 127:1 136:17 206:14 okay 4:20 5:4,10,15 5:16,19 6:1 7:3 8:11 9:15 10:23 31:9,11 35:4 45:12 51:4 58:6,9 64:15 72:11 77:6 79:6 88:17 104:3 110:5 114:4 117:18 127:15 140:11 148:13 150:7 154:3,6 161:16 163:13 172:9 192:22 197:5 198:10 200:11 201:11,14 202:14 207:12 209:12 Okonkwor 73:5,9 73:15 74:1 old 11:12 112:15,24 113:1,3,5,18 117:8 170:22 once 74:12 165:2 166:2 167:8 ones 26:17 27:12 44:19 64:13 69:7 77:17 79:19 122:1 143:18 152:22 174:4 one-month 188:13 188:22 one-on-one 38:5 39:14 46:17 one-time 77:7 one-to-one 40:2,4,4	40:7 online 107:9 onset 29:9 open 52:19 73:21 172:24 175:7 operating 49:21 operative 93:1 opinion 71:24 108:15 131:20,22 150:4 152:12 opinions 26:7 153:7 opioids 130:12 131:8,11 174:5 opportunities 195:21 opportunity 155:3 opposed 88:1 90:22 196:9 optimize 19:21 option 112:3 options 34:17 112:8 oral 171:4 order 20:18 42:6 58:7,8 137:9,12 138:17 139:2 140:2 orders 21:1,20 137:8,15,19 138:23 organized 157:21 orientees 19:1 origin 7:12 9:2,6,14 9:16 12:17,24 13:22 14:21 15:6 15:10 95:20 96:3 98:2,4 99:8 154:16 original 158:7 other's 45:1 outcome 199:2 outpatient 88:12 outright 9:11 81:21 outstanding 104:23 107:1,22 163:18 overall 56:14 57:3 57:15 162:1	overdose 138:12 144:7 overdosing 183:1 overlap 192:10 overly 45:18 88:21 oversaw 25:6,10 oversee 209:4 overseeing 38:12 overshoot 152:23 overshooting 150:11 overview 34:11 35:24 overwhelming 180:7 owing 14:23 o'clock 1:19 200:3 <hr/> P PA 185:22 PACU 137:15 page 3:5 7:6,19 13:2,4 55:13 56:3 56:20 57:7,19 58:8 59:9,22 62:4 85:19 86:1 90:5,5 102:15 104:5,17 106:13,19 107:12 109:16,18 112:9 116:13 125:17,21 126:3,4 128:7 129:5 130:15 132:1,2 145:5 148:7,14,19,21 150:18 156:22 163:12 164:13 166:4 168:14 170:13 184:1 190:24 191:16 192:23 193:1,7,9 197:5 198:23 200:2 202:1 207:6 pages 34:19,22 56:3 58:2,5 60:18 61:10 101:14 103:20 106:20
---	--	--	---	---

<p>210:8</p> <p>pain 19:16 28:3</p> <p>130:11 131:2</p> <p>139:15,21 143:23</p> <p>144:6</p> <p>pair 76:6</p> <p>paired 15:11 47:17</p> <p>47:20 48:17 74:4</p> <p>74:8 75:24</p> <p>paper 134:11</p> <p>140:15</p> <p>papers 134:2,7</p> <p>paragraph 8:11</p> <p>13:10 86:2,24</p> <p>90:5,6 112:11</p> <p>129:5 130:15</p> <p>139:19 144:10</p> <p>147:24 149:11</p> <p>164:14,18 165:13</p> <p>172:3,7 175:17</p> <p>178:1 184:20</p> <p>200:15 207:6,7,10</p> <p>paragraphs 7:20</p> <p>151:22 159:2</p> <p>201:12</p> <p>paralytic 166:13</p> <p>168:2</p> <p>parent 93:6,10,21</p> <p>part 7:9 8:15 17:7</p> <p>17:20 23:1 24:24</p> <p>25:2,7 26:11,21</p> <p>26:22 27:5,21</p> <p>30:2,6,6 31:8,10</p> <p>31:14,16,17 32:12</p> <p>32:20 34:2,10</p> <p>35:14 36:11,18,19</p> <p>37:3 39:3,12,13</p> <p>45:2 48:22 49:15</p> <p>49:19 62:18 63:23</p> <p>67:12 73:18 93:5</p> <p>94:4 96:16 102:4</p> <p>103:11,13 114:15</p> <p>114:19 115:3</p> <p>117:1,2 134:4</p> <p>144:9 157:3 160:2</p> <p>160:15 161:14</p>	<p>163:5 182:12</p> <p>185:18 186:13</p> <p>189:1 194:16</p> <p>200:8,9</p> <p>participate 23:3</p> <p>181:19</p> <p>participated 18:21</p> <p>75:10</p> <p>participating</p> <p>116:24</p> <p>particular 29:1</p> <p>33:1 34:9 36:6</p> <p>47:3,22 49:20</p> <p>91:2 110:13,14</p> <p>111:11,22 119:2</p> <p>121:3 130:1 134:7</p> <p>134:23,24 135:12</p> <p>135:21 146:22</p> <p>150:6,11 156:13</p> <p>161:8 178:19</p> <p>184:8 185:16</p> <p>198:21 202:24,24</p> <p>206:15</p> <p>particularly 14:24</p> <p>129:19 135:13</p> <p>142:2</p> <p>party 6:24</p> <p>pass 42:7 99:11</p> <p>178:21 185:22</p> <p>187:8</p> <p>passed 98:10,12</p> <p>99:21</p> <p>passing 128:12</p> <p>184:24 185:3</p> <p>186:4 195:8</p> <p>pass-fail 42:3</p> <p>patch 88:16</p> <p>paths 40:1</p> <p>patience 183:9</p> <p>patient 19:6,20,21</p> <p>19:24 20:17,23</p> <p>21:22 23:13 29:2</p> <p>29:15,24 30:23</p> <p>36:8,15 42:10</p> <p>52:17,21,24 53:6</p> <p>53:21 88:9,11</p>	<p>91:9,10 93:2,4,5</p> <p>94:21 110:13,14</p> <p>111:12,16,22</p> <p>112:24 113:5</p> <p>115:2 116:3,7,19</p> <p>117:8,8 119:2</p> <p>121:11,13,16,20</p> <p>121:22 122:2,4,24</p> <p>129:9 130:1</p> <p>134:24 135:4</p> <p>137:8,9,17 138:3</p> <p>138:12 143:24</p> <p>144:8,19,23 145:1</p> <p>149:13,16 152:1,3</p> <p>152:4,18,21,24</p> <p>157:2 158:22</p> <p>160:20 164:18</p> <p>165:8,17 171:3,15</p> <p>172:1,2,13,19,24</p> <p>173:6,11,13,18</p> <p>174:15 175:10,19</p> <p>176:1 183:1 185:8</p> <p>185:21</p> <p>patients 8:18 18:15</p> <p>18:16,19 19:5</p> <p>21:13,24 22:19</p> <p>23:4,11 33:15</p> <p>37:9 113:3 117:22</p> <p>135:2,7,13 174:9</p> <p>178:2,9 179:17</p> <p>181:2,6 183:6</p> <p>192:16,17</p> <p>patient's 19:8 21:1</p> <p>21:16 29:24 34:20</p> <p>35:1 52:22 91:12</p> <p>116:2 121:2 134:3</p> <p>151:5,19 166:12</p> <p>patient-controlled</p> <p>32:3</p> <p>paying 51:10</p> <p>pediatric 93:2,19</p> <p>117:20,21 129:9</p> <p>131:23 133:3</p> <p>135:13 139:11</p> <p>142:3,8</p> <p>pediatrics 122:15</p>	<p>122:17 136:18</p> <p>138:3,8 146:17</p> <p>peds 131:2</p> <p>PEEP 177:16</p> <p>people 43:12 45:19</p> <p>48:22 49:8,9,12</p> <p>49:13,18,20,24</p> <p>50:6 51:8 53:16</p> <p>73:2 79:24 82:20</p> <p>87:1 126:9 199:8</p> <p>203:4 205:17</p> <p>206:20</p> <p>perceive 153:1</p> <p>perceived 90:7,10</p> <p>percent 32:9 37:13</p> <p>37:22 149:18,24</p> <p>150:14 152:2,7</p> <p>153:24 159:3,10</p> <p>159:14 161:23</p> <p>percentage 32:8</p> <p>perception 23:18</p> <p>97:2 159:19 194:7</p> <p>194:9</p> <p>perform 8:19 51:1</p> <p>74:11 122:12</p> <p>143:4 161:14</p> <p>172:19 180:13</p> <p>181:19 196:9</p> <p>performance 14:10</p> <p>45:21 46:20,22</p> <p>54:12 64:17 68:9</p> <p>68:24 69:18 70:3</p> <p>78:18 79:4,12</p> <p>98:19 99:20</p> <p>117:13 145:8,21</p> <p>163:24 169:8</p> <p>180:4 181:1</p> <p>185:20,23 187:5</p> <p>194:19</p> <p>performed 56:11</p> <p>69:20,24 105:10</p> <p>128:15,16</p> <p>performing 45:16</p> <p>48:12 135:23</p> <p>164:2 173:22</p> <p>181:13 199:19</p>	<p>period 55:17,21</p> <p>62:21 84:15</p> <p>100:16 101:7,16</p> <p>106:10 116:4</p> <p>152:19 162:19</p> <p>168:13 186:12</p> <p>periods 38:15</p> <p>115:3</p> <p>permission 161:17</p> <p>persecute 182:13</p> <p>person 25:10 176:9</p> <p>183:2,2,3</p> <p>personalities</p> <p>200:21</p> <p>personalized</p> <p>110:12</p> <p>person's 190:3</p> <p>perspective 35:8</p> <p>97:22 196:2</p> <p>pertaining 1:15</p> <p>11:20 94:13</p> <p>Pete 4:7</p> <p>PETER 2:11</p> <p>peter.land@husc...</p> <p>2:9</p> <p>phase 39:16,18,20</p> <p>phenylephrine 28:3</p> <p>phonetic 40:17</p> <p>73:6 123:2 193:12</p> <p>phrased 167:9</p> <p>physical 20:19</p> <p>188:4 189:19</p> <p>physicians 22:1</p> <p>physiology 29:8,9</p> <p>picked 171:12</p> <p>175:22 199:16</p> <p>piece 178:3,5</p> <p>piled 178:22</p> <p>pillow 151:5,19</p> <p>place 147:13,23</p> <p>151:3,3,4</p> <p>placed 165:14</p> <p>171:5</p> <p>placement 88:11</p> <p>placing 165:16</p> <p>170:22 175:19</p>
---	--	---	--	--

plain 134:5	41:10 89:17	prefers 151:10	presenting 209:8	problem 96:18,20
Plaintiff 1:4 2:6	101:12 113:11	premature 112:14	pressing 176:1	118:21 153:10
Plaintiff's 85:13	120:5 137:14,18	114:3 122:18	pressure 21:16	155:13 156:13
plan 20:15 21:10	140:1 160:11	premedicate 19:24	149:13,17 150:11	160:24 177:1
32:24 33:8,16,17	191:7	preop 150:24	150:14 152:2	197:14 198:17,22
33:21,24 34:14	portions 62:19	preoperative 93:24	153:24 159:6,13	199:3
35:2,11,23 37:17	portrayed 114:14	185:11	159:18 162:24	problematic 182:6
88:19 118:4 130:9	position 108:13	preoperatively	175:22 176:5,6,21	problems 63:4
158:7 181:6	positions 23:10	93:1	177:13 178:15	77:20 81:10 97:13
185:18	positive 56:7 57:1,4	prep 111:24 116:18	179:10,12	156:10 179:16,17
planned 35:16,17	57:14,15,23 59:14	129:24 133:7	pressures 159:20	182:3,5 192:16,16
planning 118:3	60:5 84:12 107:3	134:2 135:18	pretty 8:6 33:11	procedure 1:14
135:22	108:1,2 117:15	preparation 110:7	36:15 45:9 50:12	4:13 88:12 119:24
plans 18:20 20:12	127:2 163:17	110:14,22 111:7	102:19 105:11	123:4 129:8
21:4 33:21	positives 127:15	116:16,17 118:24	128:21 174:17	133:20 134:8
played 47:8	possibility 35:2	119:3,4 129:10,12	prevents 166:12	143:22 144:6
Plaza 1:17 2:8	possible 19:20 87:5	133:13,14 134:6	previous 77:6	151:16
please 4:2 5:14 65:5	147:6 160:18	134:20 146:24	93:18 132:10,20	procedures 20:18
117:19 120:11	161:13,21 165:3	147:7,7,24 157:13	132:24 133:9	69:16 122:12
124:9 190:7	168:7 171:8 192:2	prepare 34:22	136:15 138:2	proceed 195:5
plenty 200:21	possibly 36:2 177:7	112:4,17 113:6,19	139:8 141:2 146:2	process 53:7 91:9
Plus 139:10 189:10	177:20	129:20	146:8 154:18	143:14
point 41:19 46:16	post 137:10	prepared 33:14,22	178:15	produce 207:1
88:4,5 104:4,7	postop 19:22	33:24 34:14	previously 133:2	produced 204:3
116:2 117:14	130:10 131:2	102:20 103:8	pre-made 21:19	professional 22:9
118:19 123:17	137:8,15 139:15	106:17,20 110:20	primarily 18:16,22	professionalism
125:18 126:21	postoperative	111:1,11 113:17	205:20	49:15 185:9
131:5 138:6 150:5	31:21 130:9	113:21 118:17,23	primary 18:14	program 9:4 10:9
153:14,15 154:14	postoperatively	120:20 129:11,15	45:19	10:17,18,19,22
162:17 164:21	19:16	132:14 135:11	prior 17:22 18:8	11:12 18:5,11
172:4,8,10 178:1	potentially 155:2	157:11 168:15	33:14 38:9 96:6	22:4,5,6 23:16
179:3 187:24	160:20 201:11	202:7	124:22	24:11 25:3,7,15
pointed 76:4 86:12	practices 144:12	preparing 112:4	proactive 151:22	25:18,24 26:11,21
117:11 126:20	practitioners	147:4	152:4	27:6,21 30:2,6
165:10 179:7	151:10	preps 181:15	probably 14:14	31:9,16 32:12,17
pointing 94:23	praising 157:14	prereqs 24:18	17:21 31:22 41:7	32:21 33:10 36:11
118:20 120:5,7	pre 110:12	prerequisites 24:17	49:22,22 69:14	36:18 37:1,4 39:9
156:14	precautions 128:14	24:22	77:7 119:11	39:12,13 41:11,11
points 36:5 66:10	preceded 55:24	present 2:14 20:16	121:17 134:18	41:22 42:1,12,24
152:16	preceding 55:17	37:16 49:18 50:7	143:17 165:2	43:8 44:10 45:20
poor 88:18 159:22	preclude 19:9	51:12	189:7	46:7,16,21,24
191:8,12	prefer 4:20	presentations 32:5	probation 180:6	47:8 49:5,20 50:8
poorly 87:20,24	preference 111:22	presented 15:3	182:17,20,23	51:6 55:18,24
91:4 92:9,14	152:13	31:24 32:2 108:10	186:24 187:10	56:22 62:11,21
port 88:11	preferences 19:16	119:3 167:12	201:19	63:23 64:24 65:14
portion 25:24	112:2 161:22	188:2,8 197:18	probe 165:17	65:22 68:10,11

69:18 70:4,8 72:21 73:21 78:14 79:16 98:10,13 99:11,22 100:12 101:1,10,12 105:23 126:10 178:22 189:3 191:7,23 193:16 202:23 203:4 205:15 207:21 programs 24:3,8,10 progress 20:23 38:8 progression 10:9 10:16,22 11:6,23 21:1 67:10 prompted 167:6 177:8 prompting 164:23 177:4 prone 159:24 160:4 pronounce 166:7 proper 112:7 154:9 properly 90:18 118:23 129:20 protect 116:19 protected 73:3 protection 38:19 protocol 21:18,20 provide 18:15 22:7 44:22 71:18 135:4 187:3 provided 22:12 24:4 46:7 provides 29:10 providing 25:12 46:15 121:19 150:15 174:5 provision 22:12 38:23 Prygodska 40:9 Prygodzka 40:19 pseudocholineste... 166:17 psychiatrist 190:5 psychomotor	165:12 Public 210:21 pull 109:16 pulled 93:17 142:5 206:23 punished 169:19 purpose 4:23 purposes 103:19 purse 203:20,21 pursuant 1:13,14 4:11,12 pursue 8:3 put 40:1,3 54:6 62:16 77:2 89:5 94:18 116:1 134:5 137:8 182:17,20 182:23 184:21 206:5 putting 56:15 138:23 151:18 173:22 196:23 P-r-y-g-o-d-z-k-a 40:19 P.C 2:3 p.m 184:13 Q quality 24:4 quantities 131:1 quarter 194:22 195:3 question 5:2,13,17 6:1,5 16:1 20:5 46:4,5 65:6 66:1 89:15 103:3 113:10 124:8,11 126:6 132:12 135:6 136:15 138:22 142:16 147:21 148:3 151:7 158:24 159:7 199:8 203:2 questioned 74:12 88:24 162:13 questioning 86:6 87:3 88:3,7,22	89:5 questions 4:24 7:7 13:4 85:18 87:13 89:8 90:24 93:13 104:9 110:4 132:3 136:23 138:4 139:9 140:9 141:21 173:1 200:4 quick 117:3 quicker 150:3 quite 30:14 88:3,8 quiz 135:10 quizzed 135:14 quote 202:9 quoted 105:1 206:20 quotes 202:6,21,21 206:5,11,15 R race 7:12 9:2,6,12 9:14,15 12:12,24 13:22 14:21 15:6 15:9 16:11 17:18 18:1 95:20 96:3,4 98:2 99:9 154:16 racial 73:2 radar 199:15 raise 15:10 raised 7:8 10:1 13:20,24 14:10 16:15,21 17:2,9 17:21,24 63:14,18 64:23 111:5 raising 174:3 ran 116:24 range 29:19 30:15 ranges 31:1 ranking 45:5 rankings 44:23 rare 122:17 rash 154:18 rate 61:1 rated 57:1 64:23 108:15 128:15,17	rates 58:14 163:17 165:13 168:20 rating 42:17 65:13 148:9,16 149:5 153:7 ratings 42:10 43:4 106:24 107:21 108:3,4,5,8 109:8 116:10,18 127:24 128:14 179:13 183:8,14 185:7,21 187:12,20 196:10 rationalize 199:18 199:23 rationalizing 133:1 160:16 Ray 1:7 10:1,4,8 44:9 46:19 82:7,9 84:3,17 200:22 201:2 202:1 209:9 reach 21:17 121:18 reached 157:23 158:12 react 37:4 150:5 reacted 91:15 94:11 150:2 reacting 153:13 156:13 159:18 read 65:7 89:18 105:2 113:12 140:6 210:6 readiness 93:9 reading 129:12 139:17 149:17 150:12 reads 118:2 ready 40:11 52:5 151:2 173:6,13 202:17 real 200:3 realize 173:1 realized 158:17 really 11:9 34:9 45:1,16 47:12,19 48:14 55:18 75:5 76:5 77:6,10 89:5	93:15 94:2 96:18 98:21 99:19 108:10,16 118:19 119:12 128:9 139:24 140:7 142:1 145:3 153:8 157:10 162:20 166:20 169:7 173:8,10 175:9 189:9,12 194:21 195:6 198:20 205:3,12 reappeared 125:2 reason 17:3 59:5,20 62:1 79:13 110:16 125:13,15 154:6 157:19 162:6 174:1 178:7 189:1 205:5 reasoning 153:9 156:12 reasons 150:24 199:9 reassured 200:22 reassuring 202:4 reattached 94:6 rebuttal 63:21 118:11 128:22 129:4 131:14,18 147:22 148:4 160:5 186:14 rebuttals 189:14 196:21 rebutted 167:7 rebutting 111:7 recalibrate 180:22 recall 6:6 8:10 9:7 9:9 10:4,10 17:11 24:17 26:2 28:16 34:9 44:18 58:24 59:17,21 62:15 63:20,21 66:5 68:6 69:9 74:5,23 75:3 76:14,15,18 77:15 80:8 81:11 82:7,13 83:5
---	--	---	--	--

86:22 87:7,14,22 87:23 92:20 93:14 95:3,10 97:3 108:2 110:21 111:20 119:11,13 119:21 120:3,9 143:20 144:18,22 145:12 146:20 147:4,10 159:1 160:2,14,15,17 161:4,7,9,12 165:2 166:1,19 167:22 169:23,24 170:1 173:5 175:24 177:11 180:10 184:8,9,17 185:17 186:3,15 188:24 195:3 198:9 205:3 206:23 recalled 105:18 111:2 141:10 143:2 recalling 87:15 182:24 202:11 receive 41:20 84:8 119:17 127:13 145:10 received 14:9 15:1 16:13 43:3 75:20 103:8,23 119:18 125:4 170:11 184:9 190:17,21 191:9 receiving 14:6 120:1 179:12 184:22 recess 55:4 100:4 156:16 190:8 recitation 12:7 recognize 6:21 85:11 103:7,11 168:4 183:18 198:12 recognized 97:12 134:3 156:1	164:22 recognizes 149:7 recognizing 37:7 167:20 recollect 10:14 59:4 95:16 119:19 recollection 14:8 49:6 73:8 82:5 91:23 92:11 94:7 110:11 111:10,21 116:8 129:23 138:13 140:17 146:19 147:13 151:14 157:22 158:16 162:15 186:8 192:10 recommendation 188:21 195:16 199:12 recommended 131:2 138:1 142:9 197:18 reconnect 94:16 record 4:3 55:10 89:18 100:10 113:12 120:6 203:3,16 204:24 205:5,15,23 209:18 recorded 182:5 204:12 205:10,18 206:3 209:14 recording 153:18 204:1,9,16 205:21 206:10,18,20,21 206:23 207:2 recordings 206:6 records 127:5,11 134:3 recovered 114:17 115:10,17 recovery 116:2 166:12 redirect 145:13 162:11 redirected 145:7	146:13 158:2,19 redirecting 162:5 162:14 163:4 redirection 145:10 redo 194:13 reenforced 10:9,12 reenforcing 10:21 refer 30:8,19,22 31:7 104:2 112:9 134:20 reference 103:6 104:1,6 108:22 109:18,20 110:18 111:3,23 112:22 117:6 119:1 125:18 128:23 131:22 133:9 137:5,11 138:10 139:10 141:22 146:1 148:9 150:21 151:6 152:7 158:20 159:3,6 185:6 186:22 192:23 referenced 110:20 147:23 148:2 192:8 194:16 references 31:7 102:16 131:8 136:8 142:3 referencing 77:19 139:8 referred 113:15 145:24 199:17 referring 11:21 24:7 31:3 34:14 102:24 103:16 110:23 113:9 114:7 116:23 117:7,12 118:15 119:14 120:9,19 131:3 146:2 163:3 167:16 refers 61:18 106:16 reflect 54:22 120:6 196:20	reflects 106:8 reflex 171:6 refresh 73:11 refusing 198:1 refute 88:4 119:20 120:10 196:17 refuted 131:17 152:15 regarding 130:24 197:6 199:7 Registered 23:7 regroup 196:4,8 regular 68:8 162:5 162:12,14 171:11 173:8,12 174:5,18 174:18 reiterate 143:22 relate 22:18 32:1 related 6:3 66:11 115:1 relates 109:2 204:18 relating 147:23 202:23 204:16 205:14 relation 198:21 relaxant 159:23 160:3,5,11,16,17 160:18,22 161:8 161:10,13 166:8 167:24 171:16 173:2,17,24 174:3 174:9,12,15 relaxants 28:5,6,9 relieved 82:6,7,10 84:3,18 162:16 rely 12:6,9 remediate 194:11 remember 6:4 11:15,18,21 12:8 27:24 28:9 43:21 80:18,22 81:2 87:11 88:7 91:6 95:11 118:24 121:1 122:20 135:11 141:8,16	143:14,18 164:1 166:9 167:18 184:6,15 185:12 186:10,13,20 199:10 203:6 204:13 206:10 207:3 remembering 141:20 142:23 205:7 remind 30:14 43:18 165:14,20 reminded 141:1 remove 114:19 116:1 172:18 removed 115:3 removing 94:4 rendered 42:20,23 renders 178:8 Renee 40:9 Renee's 40:18 repair 137:10 repeat 66:1 103:3 144:5 repeated 42:10 144:12 207:16 repetitions 141:15 rephrase 5:14 report 19:14,19 20:21 126:24 reported 1:22 16:9 17:17 84:16 109:20 211:7 reporter 5:6,12 107:8 211:6,17 reporting 20:24 represent 4:8 54:15 54:20 reproduce 206:16 request 20:18 116:15,20 127:11 requested 89:17 113:11 209:3 requesting 20:24 require 162:20 required 36:12
---	--	--	---	---

42:5 171:22 180:13 requirement 36:22 41:20 47:22 48:2 requirements 22:5 32:10 204:16 205:3 requiring 117:4 researched 131:5 139:12 166:16 researching 24:3 72:15 resection 91:8 reservations 169:4 residency 30:9 31:9 31:15 32:11,17,24 33:10 36:11 37:1 37:3 38:2,15 39:9 41:10 42:1,12 43:8 44:10 46:20 49:19 50:8 51:6 55:18,24 56:22 62:10,13,20 63:23 64:24 65:14,22 68:10 69:18 70:4 70:8 83:4 100:19 101:9,12 105:23 106:10 191:7 resident 50:20,23 91:15 residents 24:6 50:21,22 51:3 53:17,22,23,24 resistant 198:9 199:21 200:1 respect 46:24 48:17 48:17 63:24 64:12 81:14 90:4 121:7 respiratory 173:21 respond 151:12 164:13 responded 17:14 127:1 response 110:17,24 112:10 116:13 119:8 120:16	123:5,9 125:3 126:2,4,6 130:14 149:10,11,12 151:7 165:6,21 responses 69:1 85:13,17,23 109:17 126:1 148:15,20,23 164:13 responsible 45:20 rest 104:16 133:18 170:5 restate 124:13 result 34:24 resulting 86:7 resume 100:12 resuscitating 23:4 retaliation 7:9 13:5 retrieve 111:14 133:17 134:4 return 82:9 87:10 91:18 100:19 122:15 166:6 167:18,20 201:17 returned 75:22 201:5 returning 160:8 168:2 reversal 28:6,13 review 56:4,7,9,12 57:1,5,7,14,16,20 58:10,17,20,23 59:6,14 60:4,10 60:20 61:1,3,5,13 61:21,23 109:2 117:20 185:10 192:6,7 reviewed 43:21 64:14 107:7,8 137:5 184:12 reviewing 95:14 reviews 44:13 revisited 201:13,15 reviving 23:4 115:2 115:7 re-dose 160:9	re-dosing 161:19 RICE 2:15 right 5:20 7:4,10,23 7:24 8:10 10:13 12:4,13,20 13:18 14:2,9 16:11 21:10 24:12 26:18 27:6 28:16 30:3 30:11 31:13,17 32:21 37:24 39:16 41:12 42:18,21 43:5 44:5 46:21 50:3,12 51:6,15 52:17 53:15,19,20 55:24 56:5,16,22 56:23 58:21 60:2 60:8,21 61:12 62:21 63:1,10,14 63:19 66:4 70:13 72:1 73:8 79:4 84:12 85:20 86:18 89:5,23 92:7,15 97:19 98:4,10 99:18 101:20 102:2,2,2,20 104:14,23 105:2 105:13,17 106:4 106:17 107:1 109:8 110:1 111:20 114:13 115:6 116:5 117:9 118:5,11 119:6,18 119:23 123:9,13 123:19,24 125:5 125:13 126:3 127:24 128:5 129:13,14 132:4,8 133:14 138:18 139:6,9,19 145:18 147:24 148:4 149:5,23 153:12 154:1,4 156:5 157:14 158:11 160:14 163:7,18 163:21 164:10,15 165:23 168:16,21	171:23 173:4 174:21,22 175:1 175:12,20 176:14 179:5,13,16,19,24 181:8,22 183:22 187:13,20 191:2 191:21 193:2,7,17 193:20 201:8 202:18 203:23 207:14 208:12,17 208:19 risk 42:20,23 184:22 185:3 187:4 197:4 Riverside 1:17 2:8 RNA's 162:19 rocuronium 28:11 Rodzik 56:22 role 18:7 25:10 37:3 45:23 46:23 47:7,12 78:17,23 78:24 79:1 122:10 122:22 168:6 175:4 182:10 room 38:16,22 39:2 49:21 50:3 110:7 114:20 116:18 130:6 134:10,12 135:2,8 rotation 194:4 rough 27:12,14 RSI 165:15,21,23 167:7 rules 1:14 4:12,18 run 23:3 running 38:23 121:17 134:5 162:20 runs 47:3 rush 1:6 4:8 7:1 9:3 9:21 10:5 12:15 18:5 23:16 25:3 25:22 27:21 58:3 58:5 60:17 61:10 75:23 102:1 104:17 106:19	107:17 109:6 126:1 148:11,18 148:19 156:21,24 162:3,10 163:12 164:6 168:14 196:7 203:4 205:18 Rush's 100:11 195:23 <hr/> S S 1:17 2:8 safe 22:8 37:9 151:24 safety 18:23 23:14 24:5 42:10 149:13 164:18 185:8,21 sat 179:22 180:3 satisfactorily 136:24 satisfactory 56:8 57:2,4 58:14 60:4 61:1 78:19 104:23 106:24 107:21 108:4 128:11,14 128:17 137:1 163:18 saw 59:18 71:2,20 89:9 117:17 125:1 saying 5:3 10:5 11:6,14 12:11 15:20 17:16 24:8 33:23 35:23 46:6 46:19 60:14 62:2 62:7 64:19,22 65:12 71:10 78:6 79:18 80:22 81:3 84:20 85:2,6 88:20 91:15 92:13 92:22,23 97:7 102:5 108:7,9 112:13 115:8,13 124:5 132:17 135:24 136:21 138:14,17 140:16 155:5,19,23,24
---	---	--	---	--

156:7,10,11 158:8 160:13,23 161:3,8 165:20 167:14 170:17,18 171:21 173:14 175:7 178:22 182:3 196:21,24 203:6 209:12 says 56:8 57:3 86:4 86:12 90:10 104:7 106:14 113:9 119:5 130:10 132:9 133:12 137:7,8 139:14 140:2,15 144:7 145:20 146:9 151:22 158:21 159:11,21 161:17 163:20 164:18 166:5 168:9 170:21 171:2 172:16 175:19 177:3,24 180:4 184:11 191:7 198:14 207:13 SBP 152:1 scaring 93:13 scattered 162:3,9 scheduled 106:3 129:8 193:11 scheduling 47:4,5 48:4 112:14 school 68:7 189:17 scores 104:22 screaming 140:24 143:11 scrub 50:18,18 scrutiny 77:2,3 183:5 second 13:3 94:5 104:5 106:13 107:12 112:13 113:2,5,18,20 114:1 115:24 117:1 120:19 121:4,8,16,19	122:3 129:5 132:1 137:20 150:18 166:4 170:21 172:7 193:1,7,9 199:11 200:16 207:18 208:6 secretions 52:23 section 58:21 63:21 137:20 139:1,14 158:11 185:5 sedated 174:17 sedation 174:5 sedative 171:18 sedatives 173:19 174:18 see 8:13,24 13:6,13 36:2 60:20 79:4 85:15 86:2,10,15 90:8,12 102:17 105:6,7 107:18 108:24 109:18 110:8 111:3 120:13 123:6 124:1 132:5 139:16 145:8 146:13 148:9 149:4,14 150:9 151:6 160:8 165:6 172:5 173:16,22 175:9 190:5 193:13 194:4 197:7 199:4 200:17,24 201:13 203:23 207:9,10 seeing 69:11 124:21 189:16 190:1 seeking 8:3 189:1 seen 23:5 28:16 37:16 40:12 59:3 60:13 69:10,13,17 135:14 sees 197:13 198:17 segued 10:19 semester 168:10 sense 43:13 48:3 78:15 96:4 143:6	160:21 182:6 196:11 sensitive 98:17 sent 84:4 200:6 202:20 sentence 90:7 146:6 159:21 168:9 172:4,8 184:20 200:16 201:24 sentences 157:10 161:17 166:4 separation 93:9 sepsis 21:20 September 195:13 septic 21:22 sequentially 104:18 series 13:6 182:21 service 22:8 186:3 services 1:22 186:1 session 5:22 set 33:1 52:10 54:24 85:14 129:7 129:24 157:12,13 158:18 184:24 193:22 198:24 sets 138:13 setting 7:4 32:16 65:24 66:4 176:9 208:10 settings 8:18 171:20 setup 51:18 52:4 53:9 129:9 162:2 seventh 58:8 severe 146:18 shaken 143:8 Shannon 13:13 share 45:1 shared 101:24 102:6,19 103:5 170:4 sharing 155:15 sheet 30:13 132:11 132:21 133:13 134:14,15,21 139:2	Sheila 58:11 shelf 142:6 shield 38:17,19 Shively 142:12 shock 21:22 short 116:14,20 190:6 shorter 195:11 shorthand 211:7,10 211:17 shortly 154:19 shot 144:20 show 36:12 45:1 69:3 76:5 84:17 85:4 136:5 showed 69:5,8 71:7 88:4 showing 84:23 shows 173:13 Shumpert 13:13 sick 83:21 side 122:12 SIEGEL 2:3,5 15:24 16:23 39:21 48:24 54:24 55:3 61:7 62:4 65:2,5,9 66:6 70:20 78:9 83:10,14 89:13 98:20 99:15 100:2 102:23 113:10 117:23 124:8,12 125:9,14 139:17 140:3 147:9 148:21 155:22 161:5 204:6,10,18 209:17 siegeledlaw@aol... 2:4 sign 60:2 61:24 152:14 173:10 184:6 209:1 signature 57:10 85:19 184:3 signed 57:9 59:19 60:13 61:3 105:7 123:18 124:16	significance 167:23 significant 20:22 27:5 42:18 182:5 signs 137:16 150:9 152:20 168:1 173:6,8,12 174:1 similar 74:2 98:8 138:2 182:17 similarities 72:18 Similarly 130:23 simple 35:16 202:2 sit 8:7 11:14,18 26:9 62:1 199:13 situation 48:11 112:18 116:16 157:2 195:20 situations 22:23 48:7 63:16 six 31:21 size 52:8 110:8,19 111:4,19,20 112:2 112:5,6 118:5,8 118:10,21 129:19 133:7 sized 111:8,19 113:5,9,15 sizes 112:4,4 132:8 132:13,18 147:5 sizing 133:6 sizings 112:7 skills 165:12 169:6 180:13 195:17 sleeping 87:17 slightly 106:23 192:24 203:2 snoring 165:8 somebody 160:6 174:14 209:4,6 somewhat 200:16 soon 103:8 sorry 9:8 13:8 25:9 61:9 89:14 92:18 109:5 124:12 139:17 142:14 189:23 sort 27:11 34:11
---	--	---	---	--

38:5 55:21 71:5 72:6 98:17 155:11 157:24 182:11 speak 199:13,18 speaking 27:4 special 19:8,20 specialized 68:20 specialties 47:23 specialty 47:24 specific 35:5 77:17 130:24 134:23 142:1 160:17 161:10 173:10 specifically 131:4 131:10 136:12 145:4 172:18 199:6 specified 197:12 speculation 39:22 48:24 66:6 70:21 78:10 83:10,15 98:20 99:15 117:23 147:9 spell 4:3 40:20 99:4 spells 114:6,24 115:9,11,14 spent 32:8 spoke 68:8 135:16 spoken 188:5 spontaneously 172:13 sporadically 38:15 SRNA 9:4 18:4 22:3,5 23:7,16 24:11 36:6,22 38:6 39:12 46:24 47:8 48:11 49:5 50:1,9 67:12 73:12 78:13 101:1 126:10 197:19,20 202:23 203:4 205:15 SRNAs 39:14 45:24 46:16 47:5,16 48:4,17,21 67:9 78:4,18 79:15	80:14 81:3 86:7,8 135:9 SRNA's 45:20 SS 210:2 211:1 stable 115:16 staff 22:12 38:20 47:3,5 50:3 142:12 162:21 stance 199:22 standard 66:15 111:23 130:24 standards 23:16,19 23:23 24:3 42:6 128:17 184:24 186:4 start 4:19 18:8 21:17 29:10 37:15 39:13 100:14 102:13 113:13 133:7 191:16 202:16 207:17 started 18:9,10 24:20 31:12 41:24 42:14 62:10,13 70:7 75:24 100:15 100:19 141:1 160:13 175:22 starting 179:1 202:2 starts 90:7 112:11 126:3,4 130:16 132:3 139:19 144:11 157:9 170:17 172:4,8 193:10 200:16 201:13,24 207:8 state 4:2 182:7 195:9 198:20 211:1 stated 11:10 statement 10:7,21 65:4,8 118:14 129:21 statements 10:10 10:12 130:23 162:13 196:19	206:16 207:4 States 1:1,15 210:1 statistics 24:22 status 18:19 19:6 20:22,24 stay 122:11 148:19 199:15 stayed 116:3 123:3 195:7 staying 195:24 step 51:22 52:10 53:9 115:20 138:11 144:8 stepped 143:8 steps 51:18 52:5 154:9,9 stick 147:19 stills 104:10 stipulated 208:24 stomach 165:18 stood 181:17 stop 94:18 115:21 171:9 stopped 144:8 158:1 stopping 143:10 straight 140:8 stream 96:23 strength 172:20 173:3,15 174:7 stress 141:6 142:20 179:1 180:6,11 183:12 188:4 195:10 stressful 140:23 strike 66:7 83:14 strikes 187:7 strong 68:13 78:15 strongly 94:11 105:10 struck 110:15 stuck 159:4,11 student 15:12,13 23:6 24:6 27:16 27:18 32:5 38:12 45:4 47:14 73:11	74:3,4,9 91:16 155:12,15 162:19 169:18,22 170:2 182:8,14 183:1 184:13,22,24 185:19 students 19:1 23:18 30:15 41:21 42:5 44:22 67:5 68:11 69:12,18,20,21,24 70:4 72:17,17,23 77:16 79:10,18 81:9 82:19 155:8 156:1,3 169:3 182:16,20,22 188:11 student's 68:24 studying 195:19 stuff 87:15 style 161:24 subjected 15:22 16:10 86:6 subjecting 87:2 submit 204:5 submitted 13:11,15 SUBSCRIBED 210:18 subsequent 209:13 subsequently 124:21 substance 130:18 202:12 succinylcholine 28:12 136:13 166:13 167:21 suction 52:10,20 53:2 suddenly 124:24 suggest 180:16 suggested 88:13,15 130:22 142:7,10 177:13,22 189:18 192:1,5,11 196:21 suggesting 145:24 suggestion 131:15 131:17 142:9	146:3 151:9 188:21 suggestions 88:5 138:1 suggests 156:8 suite 1:17 2:3,8 38:23 summarizing 11:11 summary 134:23 170:16 summative 41:14 101:15 102:9 103:1,4,14,15 104:5 106:12 107:11 108:20 125:16 148:6 summer 16:18 38:10 Summing 41:16 superior 127:1 supervised 39:9 supervising 8:13 supervision 39:14 40:2,5,7 201:20 201:22 support 72:13 175:22 176:5,21 supported 192:1 supposed 121:21 122:8 supposedly 40:7 sure 14:15,18 16:20 17:6,7,20 19:24 24:7 26:4 30:23 31:2,4 47:12,17 51:14 53:14 63:22 64:15,20,21 68:3 77:12,17,19 81:18 87:15 88:10 91:11 92:21 96:19 97:6 108:7 115:22 117:24 120:19 121:10 144:21 145:4 147:11 152:17,18 153:12 153:17 154:17
---	--	--	---	---

159:13 162:22 169:6 171:24 174:23 176:23 177:21 184:5 186:5 192:4,9 197:19 202:1 205:2,6,23 206:1 206:3,24 208:22 209:17 surgeon 91:14 surgeries 147:15 surgery 19:5,10,11 19:13,15,18,22 20:3,4,6,9 33:20 34:7,12 35:22 91:7,8 94:2 117:4 146:16,19,22 147:11,16 159:24 160:4 surgical 50:21 131:3 141:3 142:4 143:10,10 surmise 8:5 surprise 86:9 surprised 201:18 survive 192:4 suspect 86:13 switch 10:18 176:2 switched 89:4 147:8 switching 177:13 sworn 4:1 6:14 210:18 symptom 174:20 symptoms 20:23 89:2 173:11 syndrome 166:11 166:14,17 167:10 167:19 syringe 53:14 54:4 54:6 syringes 128:10 136:3 system 52:14 Systolic 152:2	T table 115:17 tailor 29:24 34:20 tailored 119:1 tailor-made 129:24 tainted 78:20 take 5:21 6:1 21:4 24:16 40:4 55:2 128:19 138:5,11 141:7 142:21 143:13 151:11 152:15 154:9,10 156:15 180:16,18 188:1,3,12 189:8 189:18 190:6 194:21,22 197:3 198:7 202:8 taken 1:16 4:12,15 133:16 157:12 207:22 210:7 211:10 takes 152:17 talk 7:16 19:18 22:3 31:8 44:12 46:14 96:13,16 98:1 179:21 197:15 198:2,3,5 207:19 208:8,17 209:2 talked 20:11 49:4 62:17 79:19 90:24 91:3 92:13 95:18 96:1 106:6 114:7 132:18 135:20 145:17 147:21 152:8 159:7 163:9 169:10 179:22 182:4 185:16 186:23 197:6 199:6 talking 14:15 16:5 26:17 46:3 50:2 62:23 69:19 71:3 71:6 78:4 87:12 93:6 96:23 101:10	102:9 124:20 144:9 156:2 157:4 157:7 184:15 185:12 192:2 197:24 199:10 talks 47:10 67:8 143:21 147:12 156:2 157:10 175:17 197:6 199:1 taper 29:24 tape-record 202:22 tape-recorded 203:10 taping 128:10 task 178:21 187:8 tasks 68:18,21 180:13 199:19 taught 133:2 teaching 18:24 team 22:10 23:1 141:3 143:10,10 tech 50:18 technology 38:18 teeth 91:12 tell 25:22 40:21 43:3 47:19 67:18 73:9,20 76:16 117:15 122:21 134:17 136:10 146:4 149:1 151:18 153:17 165:23 180:9,12 191:11 194:6,8 195:15 204:11 telling 172:24 174:10 202:14 temperature 165:17 ten 49:22,24 60:18 tendency 197:6 198:4 199:7 term 38:2 41:14,17 41:21 127:10 180:15 terms 36:19 44:15	62:24 73:13 121:11 130:17 132:23 139:1 145:24 151:8 153:13 167:6,9 174:3 179:9 201:16 Terrebessy 190:4 190:18,19 193:4 193:23 194:6 195:15 197:16 198:18 199:1,11 200:6 207:7 Terrebessy's 190:22 testified 6:14 testimony 65:3 161:6 211:7 text 96:17,23 97:8 137:6 205:16 textbook 142:4,5 175:9 textbooks 173:9 Thank 4:6 53:1 103:1 Thanksgiving 188:14 theirs 45:3 therapist 67:18,24 190:2,18,21 191:11 192:21 therapy 20:19 thing 5:8,24 66:4 93:23 180:21 207:5 things 6:4 8:21 27:19 28:17 34:6 34:24 35:16,24 51:20 56:15 58:21 63:8 64:3,4 69:1 72:23 76:4,17 79:10 93:7 95:5,6 128:15 131:6 132:10 140:14 145:18 154:4 162:23 169:16	173:16 174:11 177:20,23 181:5,7 181:10,15 183:10 186:7 199:9,19 202:18 207:2,3,19 208:7,11 209:9 think 7:21 10:14,18 11:11,14 16:14 18:9 23:22 24:17 26:5,12,14,20 30:18 32:2 34:13 34:19 37:19 38:10 40:20 41:5 43:18 45:10 47:1 48:13 48:19 49:11,14 56:9,12 57:5,16 57:18,23 58:17 59:3,16 60:10,16 61:5,19,21 62:2,7 63:20 64:9,14,22 65:10 67:15 69:12 73:7 85:1,2 88:5 88:23 89:1,3 92:13 94:3,10 95:6,18 96:2 98:16 100:15,19 102:14 105:8,11 107:5,14 108:7,18 108:19 114:5 117:12 119:9 120:18 124:10 126:13 128:7,20 130:1,10 132:9 135:13 136:9,12 136:13 137:11 138:6 139:22 141:6 142:22 143:12 145:23 146:23 147:11,16 147:22 148:2 149:2 150:22 151:3,7,11,17 152:17 153:16,17 154:6,15 155:10 155:19 156:7,8 157:19 158:4,14
--	--	---	---	--

158:23 159:12 160:10 161:3 162:6,14 164:3,5 165:4,19,22 166:19 167:2 168:24 170:3,3,4 170:12 171:21 172:15 174:13,19 175:21,22 177:15 177:21 178:7,11 180:18 184:17 186:5,7,8,13 188:2,17 194:9,12 195:7 197:2 199:12,22 203:8 205:6,9,11 209:12 209:16 thinking 139:23 142:23 154:11 177:19 178:18 179:10 181:4 197:23 199:18 thinks 146:12 third 90:5 105:19 193:23 200:15 208:16 thorough 70:3 168:24 thought 14:19 25:23 26:13 40:21 75:19 87:1 88:21 91:1,21 92:1 93:16 94:1,8 95:1 95:9 96:14 97:5 97:10 115:23 117:21 150:2 169:2,11 174:21 179:2 192:10,12 201:11,18 thoughts 146:8 threaten 91:16 threats 178:16 three 14:9 16:15,16 16:21 18:15 23:2 25:8 61:10 69:14 69:16 130:1,3,4	152:19 179:7 194:2 201:19 208:21 threes 181:24 three-quarters 90:6 193:10 threw 140:15 throws 31:6 Tim 142:11 time 5:21 8:23 9:4 9:20 12:3 13:24 23:6,6 30:5 32:8 33:24 35:13,14,17 37:13,19 39:9 40:2 43:15,16,18 43:19 55:17,19,20 55:24 74:15 83:21 83:23 84:3,5,10 84:14,15 86:22 87:6,16,19,24 88:24,24 90:17,23 92:4 95:4 101:7 101:15,24 102:20 105:6 109:13 112:17 116:4,15 117:16 119:18,22 119:24 120:1 122:16 123:3 125:1 137:7,7 142:15 143:1,17 154:18 161:18 162:17,19 163:10 180:23 181:12 182:17 187:18,24 188:15,18 189:17 194:13 195:24 196:8 197:12 198:19 199:11 207:18 208:6 times 23:2 26:6 38:11 40:12 43:12 66:19 83:16,20,22 84:1,9 87:9 92:13 95:14,19 105:22 106:9 143:19 171:17,19 196:20	208:21 title 13:5 177:16 today 4:19 5:22 12:8 104:8 163:20 today's 4:23 told 14:18 15:21,21 40:3,9 42:13 69:15 71:19 72:5 72:5,7,23 73:4,14 73:16,16,19 75:11 79:10,16 80:19 85:3 86:5,17 88:9 91:11 93:7,17,18 94:15 97:20 115:20,21 134:13 134:15 135:16 136:16,18,22 140:14 141:14,14 142:1 172:19 178:20 180:3,10 194:12 198:18 201:2,21 tool 104:1 top 7:19 102:15 110:6 127:22 129:6 132:3 176:1 207:10 topic 98:17 topics 32:1 total 69:13 tough 23:17 90:10 169:1,3,10 trained 51:19 training 182:9 transcript 210:6,9 211:10 transfer 94:9 114:18,21 115:11 121:11 transferred 121:13 137:18 transferring 116:7 transitioning 207:20 208:8,17 translated 89:10 transpired 141:13	tray 157:11 treat 36:2,3 78:5 80:10 90:18 92:9 150:4 154:13 156:3 treated 72:18 75:9 75:14 80:7 81:1 87:20,24 89:6 90:15 92:6 97:12 99:13,17 141:5 209:5,9 treating 87:2 151:22 152:4 153:14 159:19 162:24 169:4 treatment 14:5 15:15,23 16:10 18:20 20:12,15 21:3,9,13,24 22:1 35:19 75:20 79:2 81:3 89:4 96:15 97:10,23 treatments 20:17 20:19 77:8 tremendous 180:5 tremendously 15:17 trending 150:9 152:15 tried 145:13 146:4 trigger 177:6 triggered 177:2,3 trouble 170:21 troubleshoot 177:19 true 45:12 78:8,12 85:23 136:21 170:24 171:14 197:1 210:9 211:9 trusted 68:21 try 5:8 10:14 19:23 48:20 122:13 145:21 166:6 180:22 194:18 196:7,8 198:8 199:18,23 202:1	trying 15:4 35:4 41:5 73:7,11 82:7 92:20 95:16 119:19 132:4,7 142:18 147:10 161:21,24 171:22 176:4,8 180:13 206:15 tube 52:8 94:17 112:4,6 129:19 133:6,7 147:5,12 147:14,17,19 175:16 176:12,17 176:21 turn 7:6 12:10 13:2 57:19 58:2 59:9 59:22 86:1 90:4 104:5,16 106:19 109:18 132:1 145:5 148:14 156:20,21 163:12 164:6,12 168:14 170:13 200:2 turned 76:9 165:3 turning 114:20 tweaks 35:21 twice 43:17 165:15 165:20 166:1 167:6 171:3 twitches 160:8 161:19 166:6 167:18,20,23 two 8:21 15:16 18:15 23:1 24:11 24:18,19 25:5,7 37:18 40:13,15 43:11 45:7 76:13 83:19,20,22 84:1 95:19 96:24 101:14 103:20 105:15,21 106:2,3 106:9,19 112:15 112:24 113:3 129:7,11 151:21 178:17,20 179:8,9 179:16,16 180:18
---	---	---	---	---

187:7,8,10 188:8 188:12,12 192:16 195:11 201:12 twos 181:24 two-hour 186:12 two-page 103:13 170:16 two-pager 102:10 two-week 188:21 Tylenol 130:20 139:23 140:13 type 91:8 93:9 143:22 144:6 types 135:8 Typhon 107:7,9 typically 49:18	unfairly 70:16 79:12,24 80:14 83:9 unfounded 77:4 unique 30:1 unit 18:22,23 19:1 19:7 41:6 United 1:1,15 210:1 universal 128:13 University 1:6 4:8 7:1 unnecessary 173:2 174:11 unrelaxed 152:3 unsafe 144:11 unsatisfactory 42:10,16 43:4 44:17,23 45:5 64:24 65:13 78:19 79:4 109:8 116:18 117:7 127:24 128:18 148:8,16 149:5 153:8 168:20 179:5,12 181:2 183:8,14 185:7,21 187:12 187:19 196:10 207:16 208:5,15 untrue 71:19 unusual 150:13 updated 135:20 urged 199:2,2 use 33:17 38:17 52:19 53:6 88:13 104:1 113:4,20 130:19,21 131:19 131:19 146:17 158:1 167:21 171:22 175:2,4 176:7,8 206:19 207:1 usual 171:1,11 usually 18:14 33:11 34:5 46:2 50:21 51:1 146:17 147:15,19	V vacuum 52:13,19 vaguely 74:4 valid 88:5 119:4 126:14 154:12 189:13 validate 196:24 validity 196:19 variable 172:12 variety 48:4 various 49:9 55:14 vary 34:3 vast 39:8 veered 158:6 vehemently 17:14 vent 151:23 171:20 ventilate 165:15,21 165:23 167:7 171:3,13 172:2 ventilation 94:4,16 119:5 120:8 172:5 172:11,20 173:16 173:23 174:8 175:20 176:6,24 177:3,6,10,14 ventilator 52:1,3 178:3,4,10 verbal 207:17 208:1,5 verbally 14:4 141:2 verbatim 202:12 206:16 verifying 85:22 Versed 28:7 171:18 versus 74:3 90:2 96:9 122:9 150:9 176:5 Vietnamese 99:10 view 107:24 114:16 134:5 155:7 VII 13:5 violation 13:5 visit 19:1 43:15 191:18 198:24 visited 43:17	visits 44:2 vital 137:16 150:9 152:14,19 168:1 vitals 151:23 vocalize 67:1 voiced 75:12,18 volume 175:23 volumes 177:16 vomiting 19:23 vouch 142:24 vs 1:5 W W 2:3 wall 52:16,18 53:5 want 7:17 13:3 16:1 55:2 56:2 60:17 73:14 104:1 110:3 126:8 173:21 190:6 207:5,9 wanted 112:5 135:17,21 136:14 137:9,11 138:14 138:17 158:22 166:18 169:19 179:21 205:1 warned 15:18 169:17 warning 207:17,18 208:5,7 Warren 58:11,18 59:6 wasn't 59:20 76:8 83:3 91:1 94:10 112:20 115:11 138:5,14,23 142:13 153:9 154:19 167:12 171:22 174:12 181:12 189:7 192:4 194:15 195:16 watch 121:8 watched 121:9 watching 39:5 wave 122:20	way 10:6 12:12 15:18 35:17 43:22 62:12 70:3 71:3 75:16 76:3,8 77:21 78:11 90:6 91:1 92:24 95:19 96:1,11 97:12 114:14 115:1 118:4 127:16 147:18 152:14 153:2,19 154:23 158:12 161:24 168:5 169:12 176:16 193:10 196:2 199:9,18 209:4 ways 8:17,18 177:22 178:24 weaning 39:14 wearing 76:6 Wednesday 1:18 week 23:2 25:5,8 31:21 100:20 102:14,21 103:10 188:12 weekly 155:1,6 weeks 14:14 112:15 122:14 180:18 188:9 195:11 weight 120:13,23 121:2 138:2 189:21 weight-based 29:22 well-being 24:6 well-prepared 163:20 went 15:1 45:15 102:6,21 103:9 129:6 137:14 141:12 158:6 166:22 177:22 179:19 183:2 weren't 39:19 54:14 76:5 89:19 114:22 182:5 we're 4:10 31:2,3
--	---	--	---	---

50:2 114:20 122:15 150:15 169:15 175:7,7 182:4 187:2 199:19 200:3 204:8 whispering 71:3,5 white 15:12,13 74:3 74:8,11 96:8,17 96:20,22 97:4,7,9 97:22 170:5,8 Whoa 93:12,12,12 Wiley 12:22 16:17 25:13 38:10 40:6 44:5 56:4 77:5,5 106:17,21 141:24 142:7 143:20 164:7 178:22 179:9 187:16 188:6,7,9,11,17 Wiley's 188:20 willing 193:16 Wimberly 1:8 15:2 15:16 70:7,10 71:10,20,23 74:18 74:20 80:6,9 81:10,15 82:3,22 83:3,8,17 84:9 86:14 92:14 95:4 95:24 97:5,8 104:11,12,19 105:5,16,22 106:9 123:8 125:22 129:8 130:5,6,19 130:20 131:21 140:21 143:3,7 145:11 154:23 155:4,20 Wimberly's 15:19 71:7 96:14 97:2 97:10,23 130:16 Withdraw 61:7 witness 3:4 4:1,4,14 4:17,22 5:5,10,16 5:20 6:2,7 107:9 120:5 190:7	witnessed 91:14 witness's 65:3 89:16 WM 194:9 woman 191:6 wondering 9:3 50:6 64:4 66:18 69:11 103:4,7 111:17 195:23 word 129:1 worded 168:6 words 11:8,9,20 13:6 94:19 115:5 206:17 work 22:10 23:2 25:3,6,10,14 30:18 32:6,6,7 38:5 40:12 43:13 49:7,9 54:14,16 54:20,22,22 56:15 57:14 58:21 60:5 63:14,17 67:3 68:12 74:12 83:17 100:18 113:23 119:5 120:8 121:15 126:22 134:11 169:21 185:23 193:16,20 199:3 208:11 workbook 142:3 worked 26:24 27:10 29:14 30:10 53:3 83:22 84:9 87:6 92:6 100:24 105:16,22 106:9 working 22:17 48:22 49:12,19 84:2 100:12,16 101:3 106:2 worksheet 139:11 worry 127:2 wouldn't 21:9 35:18 40:3 155:21 160:21 182:20,23 196:11 wound 20:19	write 53:17,18 54:1 95:13 151:23 writes 123:18 135:1 136:7,20 146:6 158:20 162:1 writing 124:2 140:18,19 written 11:17 41:21 44:15,19,23 80:19 81:20 84:8,16 114:4 115:7 124:15 149:3 170:16 207:18 208:7 wrong 43:3 82:13 93:17,22 110:8,19 111:18 112:3,6 113:4,9,15 114:15 129:18,19 138:11 145:15 171:10 174:22 183:3 wrote 11:12 12:2,3 63:8 71:10 73:18 80:15,19 82:6 84:19,21 89:3 90:2 94:12 102:3 114:15 123:23 124:1 130:10 131:7 137:7 138:21 151:20 163:6 200:5	93:20 96:7 100:3 103:17 120:1 140:7 143:10 150:5 159:12 162:13 165:4,7 169:23 179:10 180:18 184:5 186:19 191:4 195:22 203:13 208:1 year 168:11 years 18:8,11 24:18 24:19 186:16 yesterday 191:24 younger 91:8	14 58:13 59:2 106:21 107:17 16 109:7 16-cv-06109 1:5 17 86:1 200:2 18 123:21 207:6 18th 124:6,14 18-year 170:22 183 3:18 19 13:2 90:5 190 3:18
				2
				2 3:16 55:8,12 108:11 164:14 185:18 193:4 2nd 59:2 149:2,3 157:1 191:19 192:20 193:7 2's 108:8 20 92:15 95:5 96:1 123:13 125:18 126:1 149:18,24 150:14 152:2,7 153:24 159:3,10 159:14 161:23 164:13 185:7 20th 123:23 2000 18:9 2011 24:21 2012 18:10 55:19 55:23 57:8 60:23 61:16 168:10 2013 14:16,17 15:7 16:18 18:11 25:1 31:12 55:19,23 56:5,21 57:9,12 57:21 58:13 59:12 59:24 71:15 74:22 83:4,18,18 84:10 84:10 86:4,21 87:12,16,19 92:4 92:5,12,12,15,22 92:23 95:5,8,9 96:1 101:7,7 102:16 103:6
			Z	
			zero 181:14,18 zeros 168:21 181:5 181:21	
			0	
			07 179:3	
			1	
			1 3:16 6:8,21 116:10 138:9 210:8 1st 148:8 149:1,2 183:22 184:16 185:13,19 1-day 113:3 10 104:12,17,20 10th 106:8 10-minute 152:19 100 3:17 11 56:4 106:19 108:21 185:6 11th 109:20 123:16 1100 1:17 112 60:18 120 1:17 2:8 121 61:10 62:5 126 58:4,5 13 7:6,19 18:8,11 199:1	
		X		
		X 3:1 X-ray 38:18		
		Y		
		Yankauer 52:21 yeah 26:19 28:6 32:14 33:7 36:21 46:22 47:14 49:9 49:17 50:5,10,16 55:2,3 57:6 62:6 62:14 67:21 68:5 81:11 82:1 83:1 84:6 87:22 88:6		

104:13,20 105:22	30 102:16,21 103:6	85 3:17 37:13		
105:24 106:2,8,10	168:18 170:10	86 13:10		
106:21 107:13	179:15 187:19			
108:21 119:18	192:15,19	<u>9</u>		
123:21 125:18	30-34 172:6	9 109:19		
148:8 149:2 157:1	312.526.1631 2:10	9th 163:15		
163:15 164:10	312.583.9970 2:4	9:30 1:19		
168:18 170:10	34 164:6	90 32:9		
183:22 185:6,7,11	38 168:14			
185:19 191:1,19	<u>4</u>			
193:24 199:1	4 3:17 13:5 57:20			
2014 13:16,22 14:1	100:8 101:6,6			
41:1,3 87:16	102:11 109:15			
106:1	137:10 148:7			
2018 1:18 210:7,19	156:20			
211:9	4:00 200:3			
209 210:8	405 2:3			
21 57:9,12 148:14	<u>5</u>			
148:18,19,21,22	5 3:18 183:16,19			
22 126:3,4	187:3			
22nd 57:8 123:7	5/10/13 104:8			
125:5	106:14			
2200 2:8	5/14/13 106:14			
23 129:5 130:15	5:45 184:13			
23rd 164:9	53 2:3			
24 59:24 109:18	55 3:16			
112:9 116:13	<u>6</u>			
148:12,19 191:1,3	6 3:10,16,18 190:12			
200:10,15	190:13,16			
25 116:13	6-year 112:24			
26 60:21 137:9	113:1,17 117:8			
156:21,24	6/27 186:14			
27 112:15 185:10	600 185:22			
27-week 113:5	60604 2:4			
28 1:18 41:20 210:7	60606 2:9			
211:9	<u>7</u>			
28th 56:21	7 59:12			
29 163:12	7/1/13 184:13			
<u>3</u>	<u>8</u>			
3 3:17 85:8,9,11	8 61:16 193:23			
109:17 110:17	80 37:13,22			
112:10 126:2				
179:3				
3rd 107:13				
3:45 184:13				

EXHIBIT

A16

Transcription of meeting with Maricel Marcial (M), Michael Kremer (K), Mary Johnson (MJ)

K How are you?

M I'm you know doing the best I can to keep up. Studying and shadowed a few times. So I'm still scheduled to shadow at Lutheran and Racine actually where I've been meeting Jeremy and I'm gonna be taking the C exam on Monday and also the in-training exam – that's December 14-16 right? Okay. Yeah but I'm continuing c work on it, work on studying it, keeping myself you know up to date and you know, resting getting some exercise,

K In August um there were some discussions we had where

M Yes

K Did you think about – the stress – that you were experiencing in the OR um so I'm what specifically are you doing to help you cope more c with stress coming back?

M I feel that keeping myself um just exercising, doing yoga, meditating, also reviewing the things I need to learn and to improve upon. I set up like I was following the guideline that you gave me and I've also kind of when I was shadowing people I would ask them things I wasn't sure about, writing them down, actually doing voice memos after my experience with them so I know that, okay I remember encountering this in clinicals. And um I know now how to approach it, and if I had questions again, I now have more opportunities to shadow, I'd bring that up. When I actually went to Racine, they are about to um actually they're using it now – there was a rep from um I forgot – Apollo machine? Cause they're using a different machine. So I got to sit in on that in-service when they're gonna use the same machine as we're using. So I took the rep's number so I could kind of have a one-to-one you know meeting with them or discussion of my questions about the machine. I mean they're certain things of course about the ventilator that it wasn't sure. So I want to discuss that with him, so when I come back to shadow, Jeremy was gonna spend some time with me to work on that to be more familiarized with the settings and their uses.

K For the Apollo?

M The Apollo is what we have here, right?

K We train on the Apollo

M Right

K And you've had difficulty programming the ventilator when you worked with Amy

M With Amy. I think it's more when I realized what I did, I knew that okay, I understood why and I think, like I said, I was just, I felt my level of functioning was affected by the stress that I was going through. But I understood what I did, and how I should correct it. And uh, aside from that, I've talked to um the educational center at Lutheran and they're gonna have me use the intubating mannequin for infants and adults in their facility. I can even take it hope to practice on just so I can get my skills up to speed.

K So I was summoned to a meeting with Dr Halsted

M Yes

K On November 8

M um hum

K um any special reason you thought it necessary to go to Dr Halsted

M I just felt like I needed an ally and I've talked to you know some of my classmates and they said that she has this open-door policy with students, and I felt that I need to you know tell her about my situation cause I just honestly, I know that you said you gave me your word that you will support me, but when we had that meeting with Ray, it just kinda opened my eyes that you know, I don't know w if I will be supported. Especially that he just, basically predicted that I'm just gonna fail when I come back. So I was gonna be set up to fail and I felt like I don't know if I'll have the support to really succeed in this try this second try that I'm coming back. And so I really just wanted to have a consistent advocate for myself knowing that I am giving this you know the best effort that I could. But I wanna know that somebody will be there for me to oversee you know whatever challenges or like you said, there was a unanimous skepticism about my return and I don't know how you know, how else I could be equipped to face that aside from making my own preparations. I want to know that somebody will be supportive of me, that I'm making the best effort that I can and unfortunately if there is bias or prejudgment before I come back, then it just is more insurmountable than I've imagined. And so

K I don't know if you understand or if you've looked at an organizational chart, the doctor Halsted is not administratively over the college of nursing. She's over academic services at the university. She's a faculty in the nursing college. Um you told Dr Halsted that there were 4 or 5 people who provided unsatisfactory feedback for your clinical performance. And that Dr Wiley had always been supportive of you and had not provided a guidance for suggestions for improvement.

M I didn't tell her that Dr Wiley had not provided any guidance. The way I told her or how I presented it to her is that I do have 5 negative evals, but out of the 20 21 evals I have, the rest are positive. So 5 out of the 20 are negative, but the rest are positive. I didn't mention anything about Dr Wiley not being supportive of me.

K That isn't what I said.

M Okay, I'm sorry.

K You worked with Judy on 2 different occasions

M Yes

K Both times in endo, both times she expressed concerns about your clinical performance. There were 6 people who expressed concerns about your clinical performance, in addition to the evaluations there um is an email communication from Alida Hooker that expressed concern that you need constant supervision and direction when you worked with her. There was communication from Dr Pryzgodzka indicating concern that you went into a room that you got involved in a case that you subsequently told me that you had no choice but to follow the orders of the attending anesthesiologist. So I wish there

was a way you know, if you send me an email of Oct 25th saying 'thank you for your concern' and then shortly after that, you go to see Dr Halstead and you told her that you're not being treated fairly. And with all the time that we have spent addressing your formative evaluations and concerns that have been raised about your performance, counseling you about alternatives that are available to you, you really believe as you sit here that the reason that you uh took the step of withdrawing non-passing. Why would have even agreed to take this step of withdrawing non-passing if you believe that was the result of um differential treatment on the part of multiple different faculty members?

M Why did I agree to take the withdraw non-passing? Well, I didn't know that was an option then, when Dr Johnson brought it up, that was the grade that I needed dot get and because I had asked for a leave of absence, I didn't realize that was part of it. And you had, you and Dr Johnson did say that it would reverse later on when I come back. And so I accepted it with the thought that when I come back and successfully complete, you know the trimester, that it would be reversed to, that she said that it would not affect my GPA.

K It would not affect your GPA, but you received a letter from the progressions committee, which Dr Wiley chaired on August 29th which said um, you'd be coming back on probation and referred to in the student handbook that if you had taken the time to handbook of policy it indicates that if you get a second failing grade you'll be dismissed from the university.

M um humm

K and apparently you choose not to believe me or others who have spoken to you and said we would like you to be able to be successful that you you choose not to accept the counsel from people who vehemently feel for many years that your chance of being successful are slim at best and apparently and help me understand this – you would rather risk another failing grade in clinical and be dismissed from the university, rather than transfer to another program.

M When we met in the beginning before we saw Ray, you had mentioned the steps that if I could come back, you know, the first negative eval would be a verbal warning, the second would be a written warning, the third would be a determination to to um progress me to or sort of bridge me to a different program which is the clinical nurse leadership. SO that's what I understood that I still would have a chance to come back, perform, and that if it didn't work out that you would help me segued into a different program. That's how I remembered it. And so when we met with Ray, it kind of became a little bit confusing to me that the opportunity is right now or never. So it kind of changed that if I didn't shift now, then my chances of shifting later on would not be looked at favorably. Because I have s second failing grade. So my thoughts were why don't I give it a chance. At least I know that I told myself that I gave it a go and not just gave up right there an then. And then I have that option anyway later on to be able to shift to a different program from what you had explained to me.

K That's something less than clear, and I apologize for any lack of clarity on my part, but its, if you well Mary's gonna join us when she gets up from a meeting. Um, I guess at some point during the spring term it might be feasible for you to. Okay, there's Mary.
[undecipherable]

We're talking about Maricel's conversation with Dr Halstead.

MJ Mmm (emphatically)

K about um the consequences of um continuing to pursue anesthesia with you know the knowledge that another failing grade would result in dismissal from the university since she'd be coming back on probation. She seemed to have a different understanding from our last conversation about what her options were. Um when she was here last, and conversations prior to that we talked about other options that we and um, then on October 24th last time you were here I talked to you. Ray and I talked with you and then I talked with you again afterward or subsequent to that that you went to see Dr Halstead with your concern that you weren't being treated fairly in the program. Umm, so what we were talking about right as you were coming in Mary was other options as far as where we sit today, Uh it seems clear to me that Maricel's options would be to either seek transfer to another program, or take the chance of returning and um to clinical residency in spring and risk uh failing. Uh Maricel seemed to think and correct me if I'm wrong that she could resume clinical residency and if that wasn't going well that you could then perhaps withdraw and transfer to a different program.

M That was my understanding. That you said that if I continue to have negative evals then we can talk about switching to a different program. From conversations that we had before we met with Ray. So that's why in my head switching right there and then didn't seem to make sense if I hadn't given it a try yet to see if I'm gonna succeed first. And when we met before, you said that pulling out early to I guess reset myself would probably be you know a positive thing to help me be centered when I get back so I could reverse the withdraw non pass the grade that I was given then. And you said that some nursing students had been successful in pulling back for a little bit and then coming back a little more refreshed, a different perspective and you've seen more of them succeed by doing that. So that was my hope that to taking the leave of absence, reviewing studying and putting myself fin order so when I come back I do have that capacity to overcome clinicals so that was the promise that you know I took with me for the full leave of absence even though I only wanted a couple of weeks or one month to reset myself. You said that because um I don't know if it's the timing

MJ right

M that I have to take the whole trimester off

MJ right, right right. Um, you know that sometimes you know it depends. Sometimes students are successful, sometimes they are not depending on kind of the origins of the issue. So there's no guarantee

M of course

MJ so there's you know, the options um some ways trying to guess I mean on the one hand, um you're confident that you can be successful, and I know situation where students are very confident that they're not, um, Dr Kremer's right in that if there's another um probationary event which would be WF or failure, then you do run the risk of dismissal. Um you know, so that's that is the possibility but you know, there's no guarantee

M sure, of course of course

MJ I mean if you, there is a cutoff if you find you're not doing well and you withdraw before the midterm whenever that is,

K cause I'm still thinking – I'm not even sure where that is

MJ Yeah, I'm not either. I'm not even sure what week that is that a withdraw is W not a WF. Even if you're failing so let's say so if it's before the midterm

M um hmm

MJ There's no obligation on our part to say WF or WP. It just goes down as a W on your transcript. Um so maybe that gives you you know your 15 week term, 15 weeks so. It's in the registrar's office. At what point, I should know, I just don't.

M Yeah

MJ But it's about midterm, midway um and um. And then you know that would surely be more desirable than waiting longer and getting a WF. But hopefully you'd get feedback along the way. You know how it felt to you. You know, it's easy to sit here today and say "I'm fine, I'll be able to think and do whatever I was able to do". And you may get into it and say 'gee I wasn't able to come back' or wasn't you know it's not looking, I think. I think you would know that fairly soon to residency. So you're kind of, so you're not you know one to one any more, you're sort of thrown in so to speak.

M Sure

K Maricel seems pretty adamant that she will not be treated fairly and that is part of her concern going forward and why she feels Dr Halstead would be her ally in ensuring that she is treated fairly. Do I have that correct?

M I think that from a recent meeting that we had with Ray where right off the bat he said I was delusional

K Um excuse me, um, that was not the way that meeting unfolded. That statement was made, it wasn't right off the bat. He subsequently apologized for making that statement.

M Well, he apologized for making me cry but I don't --

K He apologized for making that statement. He had a daughter who failed out of a physical therapy program the week before she was due to graduate. He really feels strongly about all our students and especially somebody who's in jeopardy as the rest of us, we really want to do the right thing for our students and give them the best possible advice based on available um data that we have. Um if you continue to believe that that you will not be treated uh fairly and um even going back to August when you had the day with Amy where you had difficulty programming the ventilator, and you made this statement "Amy, please don't tell Mike about this"

M I told her not about situation but just coming to her with you know the stress that I was going through -- not exactly with what happened. I admit that that happened and I didn't tell her "don't tell him about my screw-ups" I told her "Please don't tell him that you know the stress that I'm experiencing" So

M How is that--

MJ Can I interject a second because I think I can appreciate your concern that you would be treated unfairly, but I want to point out that the other is also true, that you're not going to be given special treatment and that--

M of course, I understand that

MJ and so the the I expect as well as Dr Kremer as you know everybody expects that you will be the expectations are you will be the same as any other student

M Of course

MJ and it could feel unfair at the time, but we are committed to making every effort

M um hmm

MJ to giving you a fair shot. In residency though, there is an expectation of you performing at a certain level, so we will expect that

M of course

MJ at that level

M but the other thing to that Ray had brought up and you had brought up is that supposedly when Ray mentioned that he was meeting with Dr Kremer and me, a CRNA mentioned well "She's not coming back is she?" . And then they expressed their skepticism of me coming back, I just felt like that was one of the things that adds to the unfairness where there's already bias to me coming back whereas.

MJ What would you like us to do or what would you like Dr Kremer to do?

M I was just hoping there would be oversight so that if there is bias with how I am being evaluated that I could rely on

MJ well how do you know there is going to be bias? So if you're not performing up to par, how do you know that that's not because you're not performing up to par?

M well I don't understand that

MJ well how will you be able to tell if there's bias? What will be an indicator?

M I think that's something we can discuss and I can't really say until I'm in that situation whether I feel bias that

MJ Well my experience is that students who are not successful often feel they're being treated unfairly, and um what happens is that students who are weaker students who have had difficulty will be watched more closely because we want you to be safe. I mean this is pretty dangerous business.

M Of course

MJ and so um and student perceive that as being treated unfairly and yet on our part we're trying to make sure things are safe, so it goes both ways. So if you go into it with an expectation that you'll be treated unfairly, I think you'll be looking for evidence of that.

M Well, I guess from the experience that I had where Jill and Eva they would say that "okay I didn't tell them the right dosage for something" but she didn't really ask me that particular medication and then certain things that I did, which I don't remember doing like giving fentanyl when she was the one who gave it to the patient, and had me write it. So there are just those certain things where somethings were fabricated that I didn't feel was existent then.

K What would be their motivation for fabricating evaluations?

M I don't know, but I know that it happened to another one of my classmates too

K that

M she showed me

K Its

M It didn't happen to me, but somehow it was put into my evaluation

K Okay, that's hearsay. As we were saying before Dr Johnson arrived 6 different people during the summer term expressed serious concern about your performance. Jill Wimberly, Eva Fisher, Alida Hooker, Judy Wiley, Renee Prydgodzka. So these are a cross section of faculty members in the anesthesia program. You seem to be fixated on the idea that you have these whatever it was 5 or 6 unsatisfactory evaluations and others that were satisfactory. And you mentioned to Dr Halstead that you had satisfactory evaluations from the anesthesiologists. You were assigned one to one with CRNAs. They were spending the bulk of the time with you. Um the grade calculation that Judy and I discussed with you for residency which was pass fail is one that very heavily weights any unsatisfactory in areas like patient safety as well as the other categories on the evaluation tool. And so to go back to what Mary was saying a minute ago, you would be coming back into the clinical area having been away for um several months and you would be assigned and evaluated like any beginning student beginning residency and so you'd be working with all the different CRNA faculty and when it comes to the issue of uh perceptions of bias, or somehow selectively um looking at evaluation feedback and saying, well, this isn't accurate because they're biased or because they're fabricating. Uh, I think it would be challenging at best to try to um develop any kind of improvement plan going forward, if you're not willing to accept feedback from credentialed faculty.

M I am willing to accept if they were accurate. It's just those two--

K Excuse me—

M Evaluations is--

MJ Well who is to decide?

M Okay, I guess if there is no witness to decide had happened .

K You had multiple unsatisfactory evaluations, not just from Eva and um Jill. Judy expressed concerns on two different evaluations when she worked with you on rapid sequence induction where she had to repeatedly tell you not to ventilate the patient. Patient could aspirate

MJ Mmm [emphatically]

K We reviewed that in class, we reviewed that in simulation lab. Were you ever go into the operating room so, this is serious stuff we're talking about. And, I think Mary and I have discussed this, but um since I was asked to meet with Dr Halstead about concerns that you raised her suggestions to uh address those. We have to get this on the document. The concerns for you returning are to generate a learning contract which I've done. And um, that we would need to meet weekly

M Um humm

K To review your clinical progress. There's the learning contract.

[1-2 minutes pause, presumably to review the contract]

M Basically it's the same expectations as for you know, asked to adhere to the evaluations that we are given. SO of course I agree with this. I've also been thinking about it, of course, and I'm not sure what's gonna be in the contract but I figured this is pretty much what was on the eval, so I was hoping in some ways to that I could add something where we have this expectation of me, so I was hoping as my advisor and somebody would support me have the expectation that I need to succeed through the program, and so um just basically knowing and trusting that there is oversight with making sure the evaluations are fair and non-biased and um that if there were deficiencies that I would be directed to the way I could improve upon them and be able to progress accordingly in my training. So that's I think there's a couple of things I might want to add to the contract that you have these expectations of me and I in good faith would trust that you would support me to and be on my side reasonably um would you know planning my return so that I could you know successfully complete the training. So that's all I ask too.

MJ Um humm.

K How would one guarantee--

MJ Yeah, that's hard to guarantee. I think that I was gonna say I think that the um meeting weekly is a good idea for both cases. I think that um the again you know, bias is in the eyes of the

M Sure

MJ There's always perception and perception is very hard to figure out to verify. In fact, this person is biased or not. But I think meeting weekly and discussing your progress of how you're doing and if there are issues bringing in the clinical faculty member and sort of nipping some of it in the bud. Um, you know I think that the I think the only real way to ensure you know, not being biased and given a fair shake is to right of the bat showing that you are clinically competent.

M of course

MJ and I think that the, I think people will give you that fair shake, I mean I don't think anybody is out to flunk you out or anything like that. So I really think the onus is on you in terms of your performance and I think if people see that you're taking this seriously, you've used the time, you're able to perform competent competently, then you know, people will be treating you with you know, as they would any other student. And so, um, I would say that um that there uh you know faculty don't have a desire to sort of flunk you out or anything like that. They have concerns, and I think that's rightly so, they are concerned about safety. But only you can show that those concerns are unwarranted.

M That's my goal is just to be able to competently perform and basically meet the expectations they have of me and hopefully][???] if I could. And like I said my main thing is that uh that I do feel that sense that I am supported that if I need that guidance or direction that if deficiency is noted that I will be put on notice and given the right um advice as to how I can approach it and make it right. And like you said, a fair shake.

MJ Yeah, I think meeting weekly is a very supportive offer. But I think if people wanted you to sink or swim, they would have, Dr Kremer would just say "okay you're on your own there". But the offer to meet weekly, um is you know, aside from keeping on top of potential issues, but I think it's also --

M I do appreciate that

MJ It's a support for you. Um, you know I also think um to not the OR you know my background is not OR and it's not anesthesia, but having spent a little time just wandering around and hearing about it from students, it's it's you know, it's a tough environment to work in. It's not for the tender at heart, and so um I think that's not gonna change. And I think it's rough on anybody. Frankly I'm not sure I would have the you know, the ability to you know, weather this. And this is here as well as on the outside world and wherever you go. So it's a tough world where there are high expectations and it's life and death

M Sure

MJ So I think your skin has to be a little bit thick too

M Yeah

K knowing this is a tough environment. You can, you know, it's commendable that you sought out ways to deal with stress, but it doesn't go away when you're in the OR for days of indeterminate length, cases that change and high acuity patients, and uh, you have to be able to respond to questions and justify your actions. Um so you've had discussions about that before, freezing up and not answering isn't an option -- well it's an option but it'll just result in more low evaluations forwards because if you can't demonstrate to people that you are cogently processing information around you and that you know your drugs and fluid calculations, and airway equipment. Um they'll rapidly lose confidence.

M Um humm

K So that's going back to a conversation last month and beginning the conversation today, uh, what Dr Johnson was just saying, it's really hard and it only gets harder as one goes along, and you just have to

be prepared for that. And so um some of stress-reduction kinds of things we've talked about, I'm not sure how it would carry out. Stress is in the OR and uh it's something to think about.

MJ I think you'll know - it's a big unknown - I think you'll know that pretty quickly. Um, but yeah, I think that as Dr Kremer said, we expect that students who graduate will be able to walk into this really highly stressed. It's not for everybody. SO you know, I think, you know it sounds like the learning contract that's good, I think that the opportunity to meet weekly is something that you can take advantage of in terms of you know, if there are things that you are unclear about. That's quite a bit, that's an offer of time and support. You know, it's an opportunity if something is going on to remediate it at the moment it's happening. Or not quite the moment, but shortly afterwards. Um, I guess I feel pretty confident that that is probably the best you know, the best we can offer in terms of assuring that you'll be treated fairly. Um, anything else, I think would be, that you would be treated differently and that you wouldn't be given the same, um there wouldn't be the same expectations as there would be for everybody else. So we have to maintain the same expectations.

M I know there's standards to be met

MJ Right

M and I'm not trying to you know, go below that, or find a way to ease out of it. It's I know that it stands the same and I've actually been given a rare favor of being able to move back and recalibrate myself and using that time wisely by studying and seeking experience that would help me be at least up to date and be in the environment for the period of time that I've been away, so that when I've come back it won't be like a whole culture shock. So, yeah, I've I definitely believe that standards should be upheld and that's what I'm working on doing, to just continue to make my efforts of quality level and be able to meet the expectations that are given to me.

MJ So really that's the policy. SO how does that sound?

M You know, you mentioned before, let's say, like you said if things - I just wanted to clarify that if things were not as expected and there is that, there is a period of time where I can make the decision to switch to a different program, or is that not a different option any more when I decide to come back.

MJ You know I think that, I don't want to speak for uh Dr Hixx who is running the program. But um I mean so there's an opportunity to um, there's a period of time in the beginning where if you decide to, "gee I really miscalculated" cause you never know. Just as faculty don't know and you don't know until you get into it how things are going to pan out. There's a period of time where you can withdraw from clinical without a penalty in the sense that there's just a W and it doesn't go on another ?. And then it would be a matter of talking to Dr Hixx about what it would take to transfer. I think that you could, if you really wanted to know what the options were, you could set up an appointment with him and talk about, would he accept you into the program. That's for clinical nurse leader right?

K The one masters option that we have besides the graduate entry masters, the other advanced practice tracks have all transitioned to DNP, so that would be involve fresh application.

MJ But the clinical nurse leader, I mean certainly the bulk of your courses, although there's some, there's some of their courses that they have. But you certainly could find out more about that that

might be useful to um, call him and make an appointment with him and talk to him just so you know what that entails and what the options would be.

M Um, so at this point

MJ Where do you work – do you work now?

M Lutheran General Hospital

MJ In the ICU?

M Yes

MJ And that's gone well?

M Yes. I've put hours there, and at the same time I go to Racine for shadowing CRNA but I've also shadowed anesthesiologists at Lutheran. So I've been invited to, if ever I need to continue shadowing, that I continue with Dr Odemo {??} And he allows me to do everything. Run the case, and he's – he does the documentation, though which. So with him, and the CRNA at Racine I am also open to shadowing like whenever my uh CRNA was there that I know.

K How many times did you shadow since August.

M So 3 at Lutheran and then with Jeremy about 5. And then we have till the end of the year, I am still good, but actually until June next year because they were just basing it on the papers that I sent them. One of them will expire in June which is the ?? for TB testing, so as long as that's all up to date, then I can continue to go there to shadow.

MJ That was good that you were able to do that.

M Yeah they,

MJ Did you find that that was useful in terms of your learning, that

M Yes, cause the cases have been interesting. There's even one OB case which – I haven't been to OB here, so there was a lot of things that I learned through that. And my friend, who is the CRNA there also spends time to go over theories like on our downtime we'd go over equipment and he would ask me questions and you know, just kind of direct me to subjects that I can focus on that would be very practical to a case by case basis. That's like sort of the bread and butter with anesthesia cases.

K How have you approached the outline that I gave you

M SO I've been sort of pairing it with Valerie (?) and Prodigy. With Prodigy there's a weekly recommendation of what subjects I should be doing for board review. SO I would take the quiz, and I've also taken the simulation exams. And also a little bit of the board exam simulation. So I would check off what system was in that Prodigy that I covered, and then the outline that you gave me to make sure that I cover the things that I need to cover. Plus with Valerie too, I carried it around with me on a thumb drive so that when I have down time at work, I can just plug it in the computer and pull out some review

questions there and the materials, and then off and on refer to the textbook of things were unclear, I need more information about.

MJ Um humm

K Please help me understand here as far as I've never had to do a learning contract. My impression was that was something that was generated by um faculty so when Maricel was talking about adding language to the contract um is that something that can include hers?

MJ You know I think that there um you know, any contract is a mutual agreement. I mean I think that um you could add this in writing that's an expectation um. Knowing that its um you know it's a very hard to you know measure thing

M Sure

MJ and I think part of um part of the discussion is you know, realizing that the support that you're being given is, weekly meetings with Dr Kremer and you know, to talk about how things are going. So that's a two way in terms of how are things going from your perspective, how are things going from the faculty perspective. So I mean I think certainly you could write that in as you sign.

K I would have to review any language before I'd be willing to sign.

MJ Oh, absolutely.

M I've thought about it, and I've written something out, and if that's agreeable with you, we could just tag it to that contract. I have a copy here, and I'm not expecting a whole lot. But I wrote this promise that I would be treated fairly ??? ?? with my experience.

[pause]

MJ Um, The one thing I would maybe add is, um you know, yes, 'this is a learning environment and we want you to learn. It's also a residency where we expect that there's a certain degree of independence then when people are in clinical. So there is, when you say that they'll be, you'll be given guidance in ways that I might rectify and improve on those areas, that is true, but there could potentially be a point at which there are so many.. let's say you are not successful, let's say the difficulties you had in the past are repeated, that the guidance won't go on forever and ever.

M I understand

MJ So that would be my kind of my issue with the middle part would be that. It sort of gives an open ended, that you'll be given unlimited opportunities to rectify and improve upon those areas which are not accurate.

M Sure, okay.

MJ I'm not sure how you would word that.

K And as far as that final sentence goes: "I expect that those assigned to evaluate me will do so without bias and that there will be oversight to ensure that this is the case" How would you suggest that this is operationalized.

M I think that when we meet just having you know, um that conversation of, I don't know how that they would go by, but if I felt that before things that I've not said were evaluated meant that, that I felt were added to that then, it's just something that needs to be looked into I think.

MJ You know one of my big concerns is that how will you know that there is bias? And so on the one hand, and so I guess it is it really comes down to a legal [thing?] really because you know, we know, we tried the best we can in all our agreements to treat every student fairly. I know there are students who think they are being treated unfairly, um, but but often - sometimes their behavior means being treated differently because they need more oversight. Or they don't want to be quizzed like every other student. And so, the concern my concern about putting something like this in writing is that it it's really hard you know not sure how you know that there's bias. You know if you're not successful, does that automatically mean that there was bias.

M That's why I think that like you said, the weekly meetings will be –

MJ I think the weekly meetings will be important. I think it just comes down to a leap of faith. If you really don't think you're going to be given a fair shake, then you should probably think about an alternative. Otherwise, there's just – it's just too difficult to figure out if you're being treated in biased – if you're obviously if somebody's out and out rude to you, that would be against all of our codes of conduct regardless of who the student is and who the faculty members are. People need to treat you with respect, they need to treat you – obviously not being rude and inconsiderate of you and all the things that would go against our values here at Rush.

M I think that is

MJ Yeah, that doesn't need to be in writing.

M OK

MJ That's part of our medical center values. Part of who we are, it's the college of nursing. So I don't see that as having as needing to be written. So if you were treated rudely, if you disrespectfully in some you know way, um, then that certainly would be something I would expect you to bring to Dr Kremer. My experience is that students feel their biased as they're being quizzed or watched over carefully. You know that's gonna happen. You know because we don't want you harming somebody.

M Of course

MJ And so and that's gonna happen in the beginning until you prove yourself.

M Um humm

MJ That you are in fact doing well. And it sounds like you've taken a lot of steps, and but there's no guarantee either. You know because of you know, you're not in that high stakes situation. You may be

fine and then people can be "oh, okay" and they can back up. But I think my guess is that people will be watching you pretty closely which may make you feel like you're being treated unfairly.

M I understand that< I expect that there would be close watching me, like you said. Just the behavior of professional behavior, being able to... if we have a rationale for certain things and not being treated rudely, especially in front of other teams, is one of the expectations I have--

MJ And we would expect that of any faculty member with any student. So in that sense, to not expect either positive or negative that you would be treated any differently, I think is um, a realistic expectation on your part and um you know part of Dr Kremer's job is to ensure that the students be treated fairly in general. And so um if there are any situations that seem really egregious, that would go. The weekly meetings would be the opportunity to talk about that. But I think there's a, Dr Kremer has given you the assurance that you'll be treated fairly. It becomes.. there's a leap of faith. There's no written anything that

K I think there's kind of the gulf between how fairness is being perceived.

MJ Yeah, and that you know, I think that that often is the case. And so... So it's really in your, the ball's' in your court, I think. Um

M So, like you said, there's whatever I wanted to add as far as my expectations, that's something like. Is there anything of that the things I mentioned I thought of that we can add to the contract so we have an—

MJ You know, I think if there's something concrete and measurable that we would like ,we can consider that. This is very vague.

M Um hmm

MJ And so I think it would not be to anybody's best interests to write. What we have here is much more behavioral kinds of things

M Um humm

K Just from talking to others, it's not my impression that learning contracts are typically negotiable. Learning contracts are developed when performance deficiencies have been identified and conditions for um remedy remedying those deficiencies are imposed. Or maybe I'm saying something...

M I'm definitely agreeing with everything here. These are things that have been expected of us from the start of clinical I imagine. Even before residency.

MJ You know, I think that part of the contract is a two way thing where the agreement is that if you – if you're doing this, you're not going to be treated unfairly. That goes without saying. It's implicit in this. That if you do these things you won't be treated unfairly. There's nobody that has any axe to grind. There are concerns about your behavior and concerns about your ability, but if you do these things, you will be treated fairly. Does that make sense?

M Yeah it does

MJ It really is in your, it falls back in your court to be able to you know show that you have what it takes to be successful in this.

M Um humm. Coming back, I will be expected to perform at the level of my training before I left? Pretty much in

MJ Beginning residency

M Okay. Yeah, I just wanted to clear that. I'm not trying to sort of downgrade my abilities or the things that I've put out, but I am still a student, and I as best as I can to not have any errors or perform or have deficiencies, some things will arise where I need guidance with learning things. And so I just wanted to clear that, to make sure that when I come back I would be expected to know you know, at the level that my classmates are in, um.

K Your classmates, the people you started with are already at a different point. And they're training, they're doing specialty rotations. They have been in clinical since May. You have not.

M Yes, I understand that, that's why I wanted to.

MJ So it's really back in, you know as if May is starting all over again. Which gives you, I mean an opportunity to you know, make up that time so to speak. On the other hand, residency is different than your clinical rotation where you're given a lot more one on one guidance.

K And actually that's normally how it works. The first few months they're one on one with the CRNA.

MJ Their residency?

K And they have to demonstrate their ability to work with, without continuous supervision before they're put into specialty residencies, specialty locations.

MJ So you're a student, but you're not a beginning student.

M Umm, so I'll sign this and, so this term would be then another 15 months when I start in January, I would be another 15 months of that training which is from January to March.

K What we talked about is that your graduation would be December of 14 to ??

M Um humm. Okay because I was thinking of until March of 2015 if I were to make up 15 months starting in January.

MJ Is a residency 15 months or 12 months?

K In the master's curriculum 15 months and so, she completed 3.

M So then it still stands, hopefully that 2014 would be where I complete.

K Plus you get 20 vacation days. But her work for cause I know I found it in notes from previous meetings, I think I need a clarification about back in August, was the progressions decision, it doesn't negate her work from summer does it?

MJ Well yeah, because it was a WI.

K So There's the thing--

MJ So it's basically starting over.

K So then that would push, um graduation back to the end of spring of 15.

MJ I mean I think that's to your best interest in the sense of starting off from the beginning. If you had been successful in the summer, we wouldn't be sitting here. So...

M So it would be

[inaudible exchange]

MJ Okay

M Is this my copy?

MJ You should probably make a copy. Once you sign, I'll make a copy.

M Okay.

[pause about 1 minute]

M So like you said, the fairness its inherent in that contract. Basically you know my expectations here would be met by—

MJ I think so. I mean I truly I really um no one has an axe to grind, but there is an expectation that you'll be successful.

M And that's understandable. It's just the impression that I got at the last meeting when Ray said that you'll just come back and fail and I told you so" didn't seem very supportive of all the efforts that I've been you know, working on this time. With the hopes of what ?? had mentioned before I took the leave of absence would hopefully rejuvenate me and—

MJ Well I do think there are um different ways of approaching it and one way of approaching could be "okay I'll show you I can do it".

M Of course.

MJ [to someone else] How long are you around? {reply}...

MJ So I would take that stance of you know,

M That's what I've been fighting all this time for this and just really , you know, making the most of the time that's given to me, and I'm hoping that when I come back I'm able to put out those efforts for the preparations that I've made these past few months. It is challenging to, even with shadowing, being able to transmit that when I'm actually in the situation.

MJ Yea, yeah

M So I can only hope for the best.

MJ Um humm. Yeah, that's all anybody can do.

M And the main thing is that I do get that consistent support.

MJ I would not focus as much on that

M Sure

MJ The main thing is that you perform.

M Perform

MJ And then you are getting that support in meeting with Dr Kremer and you'll find that the doubters will be fine.

M Um humm

MJ If there are doubters

M I find there is a lot of really supportive staff. The CRNAs I've been assigned to have been mostly supportive. I'm not saying it is going to change. I have faith with the decency and the professionalism that the staff has. Yeah, I'm pretty optimistic of the return...

MJ Alright... alright. Sounds good...

M Thank you for coming to

MJ Sure, sure. See you later.

[pause]

M [some talk, but very quiet/distant] .. coming in for simlab I signed up for two other Mondays to meet with you – is that okay? Or do you want me to just...

K Inaudible

M Can we meet prior to my start in January. And you said 2 days in the Sim Lab, 2 Mondays in the Sim Lab would be enough. And uh, I think I gave the 2nd and the 30th and also the um 24th maybe? [inaudible].

K Let's just concentrate on days [inaudible]

M So Monday, uh you said Mondays would be ideal, right?

K Any day can work but tell me when you're available.

M I'm available after the 18th onwards.

K Of December?

M Um humm, does that work for you?

K Sure

M So it's you and Keith who can go through the Sim Lab with me?

[END]

EXHIBIT

A17

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

MARICEL MARCIAL,)	
)	
Plaintiff,)	
)	
vs.)	No. 16-cv-06109
)	
RUSH UNIVERSITY MEDICAL CENTER;)	
DR. MICHAEL KREMER, in his)	
individual capacity; RAY NARBONE,)	
in his individual capacity; and)	
JILL WIMBERLY, in her individual)	
capacity,)	
)	
Defendants.)	

The continued deposition of
MARICEL MARCIAL, called by the Defendants for
examination, pursuant to notice and pursuant to the
Rules of Civil Procedure for the United States
District Courts pertaining to the taking of
depositions, taken before Erin McLaughlin, CSR, at
120 S. Riverside Plaza, Suite 1100,, Chicago,
Illinois, on Tuesday, March 6, 2018, commencing
at the hour of 9:30 o'clock a.m.

Reported for
MAGNA LEGAL SERVICES, by
Erin McLaughlin, CSR

Page 213

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14 MR. PETER G. LAND and MS. KAREN L. COURTHEOUX,

15 appeared on behalf of the Defendant;

16 ALSO PRESENT:

17 MR. JOSEPH MENDELSON.

18 * * * * *

Page 214

1 I N D E X

2 THE WITNESS: MARICEL MARCIAL

3 PAGE

4 EXAMINATION BY:

5 MR. LAND

6 215

7 EXHIBITS MARKED:

8 No. 7 215

9 No. 8 248

10 No. 9 272

11 No. 10 275

12 No. 11 277

13 No. 12 279

Page 215

1 (Witness sworn.)

2 MR. LAND: Good afternoon, Maricel. Back for
3 the second session of your deposition. You are still
4 under oath. The same basic ideas of how to conduct
5 the deposition will apply as before.

6 I just have to ask you one question.

7 Are you on any medication today that would impair your
8 ability to remember or to testify?

9 THE WITNESS: I am not.

10 MR. LAND: Good.

11 MARICEL MARCIAL,

12 Called on behalf of the Defendants, having been first
13 duly sworn, was examined and testified further as
14 follows:

15 DIRECT EXAMINATION

16 BY MR. LAND:

17 Q First I want to marked an exhibit, number
18 seven?19 (Marcial Deposition Exhibit No. 7
20 was marked for identification.)

Page 216

1 I don't want to spend a lot of time on
2 this Exhibit 7. Exhibit 7 is a copy of the documents,
3 and it's about 175 pages that we received last night.
4 I just have a few questions to you to help orient me
5 or to orient us as to what these are.6 So the first page it looks like is a
7 document that runs for three or four pages. What is
8 this?9 A So this is our care plan for anesthesia,
10 for the anesthesia that we're going to provide that
11 SRNAs are advised to prepare for their cases, their
12 individual cases, particularly those that are more
13 complicated.14 Q So this is something you prepared in
15 advance of a case you were going to be working on?

16 A Yes, the night before.

17 Q And you called it your care plan?

18 A Yes.

19 Q How do you know which case this care plan
20 related to?21 A How do you know what case I'm going to
22 have and which one to prepare for?

23 Q Yeah.

24 A So we look up our cases the night before

2 (Pages 213 to 216)

Page 217

1 and our case assignments and then basically find out
2 the history on the patient, what type of procedure
3 they're getting or they're having done; and then we
4 have several book references that we type up, some
5 information that will guide us the next day when we
6 provide for anesthesia.

7 Q I meant something else. I meant if you
8 look at this particular care plan that starts here, do
9 you have a way of matching up a care plan with an
10 evaluation date or a CRNA who provided that
11 evaluation?

12 A Usually with the data that we have here
13 and also sometimes we include the date.

14 Q That's what I was wondering. I didn't see
15 a date anywhere on here.

16 A I think more on my laptop there would be a
17 time log as to when I made this particular care plan.
18 That's how I know which date I did it and when I
19 performed the procedure.

20 Q I noticed a couple of times in here there
21 are some care plans where it looked like there was a
22 CRNA listed at the top and often there is not.

23 A Yes.

24 Q Is there any reason for why there is

Page 219

1 contain the care plan from June 20, 2013 when you
2 worked with Jill Wimberly?

3 A Can you ask that again?

4 Q I thought you said you looked and you
5 don't have the care plan from June 20, 2013.

6 A Yes. The current laptop I have right now
7 I couldn't find the care plan that I did from
8 June 20th, so I'd have to figure out which laptop I
9 had then that might still have it.

10 Q So you might still have it. You are not
11 sure?

12 A I'm not sure, yeah. First of all I'd have
13 to look if we still have that laptop or if that's one
14 of the ones that we gave away.

15 Q Okay. So you had these in hard copy
16 somewhere?

17 A Yes.

18 Q How did you end up with them in hard copy?

19 A Well, I produced a copy to bring with me
20 to the case; so some of them I was able to keep. Some
21 of them I guess I stored somewhere or had scattered
22 because I didn't really think of like keeping all of
23 my care plans through the years. I had almost two
24 years of clinicals; and almost every case -- not every

Page 218

1 sometimes and there isn't other times?

2 A Not really. It's just really a rough
3 guide for us. Occasionally they would ask to see it,
4 but it's not necessarily required to write their names
5 there or even to write our names sometimes. It's just
6 to have handy for our own reference.

7 Q Did you look through these before they
8 were produced by your lawyer to us?

9 A Yeah. I actually looked them up.

10 Q Do you know if in this group there is a
11 care plan from the day you worked with Jill Wimberly
12 on June 20, 2013?

13 A I could not find that particular one.
14 I have switched to two other laptops before this. So
15 it might have been in one of those which I'm not sure
16 where that laptop is anymore.

17 Q Okay. So do you know what dates any of
18 these care plans are for or what years?

19 A I think this one -- I'd have to correlate
20 them with another laptop of mine to see if that's
21 where I got it because when I submitted this to
22 Elaine, this was already in hard copy. I didn't
23 retrieve this from the laptop is what I'm saying.

24 Q But you're sure that the laptop does not

Page 220

1 case, but towards the later time, I would do a care
2 plan every day that I am in clinicals.

3 Q So you had a dispute I thought when you
4 communicated with Jill Wimberly about whether you had
5 a care plan for that day on June 20, 2013; right?

6 A Yes.

7 Q Did you make an effort to keep that care
8 plan?

9 A I did; and for some reason, I was only
10 able to retrieve like part of it. I'm not sure if
11 some of the papers got taken away with the patient
12 records. So the only thing that I remember that I was
13 able to retain and had laid on the top of our work
14 desk during our case is the pediatric anesthesia
15 worksheet which is similar to that; but, like I said,
16 on that particular day. I don't know where that
17 record is.

18 Q I guess what I'm getting is I believe you
19 said that you had a ten- or eleven-page care plan for
20 June 20, 2013; right?

21 A Yes.

22 Q And that you tried to show it to Jill
23 Wimberly but she wouldn't look at it?

24 A Yes.

3 (Pages 217 to 220)

<p style="text-align: right;">Page 221</p> <p>1 Q And you later offered to show it to Mike 2 Kremer; right? 3 A Correct. 4 Q But you don't have that anymore? 5 A Not that I recall. 6 Q And you didn't make an effort to keep 7 that? That's what I'm wondering, what I'm trying to 8 understand. 9 A Like I said, when I left the case, I think 10 I only had maybe two pages, three pages because 11 originally, like I mentioned before, at the start of 12 the case it got mixed in with the patient records 13 which the OR nurse brought to their work bench. 14 So when I went to look for it, I think 15 the only thing I was able to retrieve was the 16 pediatric anesthesia worksheet; and actually part of 17 that ten-page prep is the procedures for caudal 18 anesthesia which I actually have in my iPhone. But it 19 doesn't -- It's just basically a screen capture of 20 that caudal anesthesia from a book which I then 21 emailed to myself and then printed. 22 Q Here is what I'm trying understand. 23 A Sure. 24 Q Didn't you offer to Mike Kremer after</p>	<p style="text-align: right;">Page 223</p> <p>1 A It's in that laptop like I said; and, 2 like, we have changed two laptops later on, and I 3 can't find that exact care plan now. It don't know if 4 we failed to transfer it to my newer laptop, so I just 5 can't find it anymore. 6 Q Did you ever submit that care plan in any 7 of your appeals that you filed with Rush? 8 A No. 9 Q Why not? 10 A I can't find it. 11 Q So you couldn't find it back then either? 12 A No. I couldn't find it. It wasn't 13 something that I was asked to produce. 14 Q But did you look for it back then? 15 A I think I tried look for it, and I'm not 16 sure at what point now that I've changed or where to 17 look for it; but I just couldn't find it. 18 Q I just want you to turn -- Some of them 19 don't have numbers; or if they do, I can't read them. 20 Can you turn in your exhibit to -- I don't care which 21 page -- the notes that look like this? 22 A Yeah. 23 Q There, any one of those. I just want to 24 know what are those notes?</p>
<p style="text-align: right;">Page 222</p> <p>1 June 20, 2013, didn't you offer to him that you could 2 show him your care plan from that day? 3 A Then, right then. 4 Q Yeah. 5 And you didn't do that. Did you ever 6 share that with him? 7 A I shared with him the pediatric anesthesia 8 worksheet and then a couple of pages for which he 9 commented, It seems like you highlighted some of the 10 drugs here but you didn't highlight this one. So we 11 were going through a couple of those pages with him. 12 But the rest of it, like I said, it wasn't the 13 complete ten page that I was able to show to him. 14 Q So you lost a portion of the paper copy in 15 the OR or in the case that day? 16 A Yes. 17 Q But you had the electronic version 18 somewhere; right? 19 A I believe so. That's what we have been 20 trying to locate. 21 Q At the time in 2013 did you have the 22 electronic copy of it? 23 A Yes. 24 Q So what happened to it?</p>	<p style="text-align: right;">Page 224</p> <p>1 A So when we do in-hospital assessments of 2 patients, if a patient is inpatient, then we put like 3 the basic information on them. 4 I also write like little notes after a 5 particular case, like this is what I did, this is what 6 I learned from that case, you know, particulars about 7 the patient's planned surgery, if there was anything 8 significant that happened during the case that I 9 could, you know, study later, yeah, just tips for me 10 to review later of things that I've learned from the 11 cases. 12 Q So there are notes that you made after a 13 case about the case? 14 A Yes. 15 Q That was your practice to do? 16 A Usually. 17 Q In the notes that you have in here, do you 18 have notes from June 20, 2013? Do you know? 19 A No. I don't think I had notes from that 20 day because it's not dated; and that was a very short 21 run. Like I was only, you know, kind of actively 22 involved maybe for half an hour, and then she 23 dismissed me. 24 Yeah. It's not dated, like some of</p>

Page 225

1 this.
 2 MR. LAND: Elaine, the only other thing I would
 3 note, if you look at these, many of these pages are
 4 very hard to read from the copying. I don't know if
 5 you have original copies of these that you can make
 6 copies of.
 7 MS. SIEGEL: I can try to get copies.
 8 MR. LAND: Some of these are completely
 9 illegible, like this page.
 10 MS. SIEGEL: I don't have the -- If what you're
 11 asking me is do I have the originals, the answer is
 12 no. Can I make get better copies, I believe I can.
 13 MR. LAND: Okay.
 14 MS. SIEGEL: Or I can certainly try.
 15 MR. LAND: Q Maricel, do you know if you
 16 have --
 17 A I think are those are the Post It notes
 18 that I have the original for.
 19 Q You do have the original?
 20 A Yeah.
 21 Q What about the notes?
 22 A I do.
 23 Q You have those too?
 24 A Yes. I have the notes.

Page 226

1 MR. LAND: So I'd just like to get copies of
 2 these that we can read.
 3 MS. SIEGEL: Okay, sure.
 4 MR. LAND: Q Then later on there is some forms
 5 that look like they're not filled out.
 6 A So sometimes --
 7 Q Do you see what I'm looking at?
 8 A Yes.
 9 Q Marcial 1243, is this like a draft or
 10 something?
 11 A Yeah. It's just a template because
 12 sometimes a patient gets added on; and basically if a
 13 patient doesn't have a prior history and all I can
 14 gather is the type of surgery this person's having,
 15 then I fill up the rest on the day of or before in the
 16 preoperative area.
 17 Q One last question I have of you just about
 18 this stack of documents, any of the care plans that
 19 are in there, are they for days where you got
 20 unsatisfactory ratings?
 21 A I don't know how many are here.
 22 Q I don't need you to look through them all,
 23 but do you know? Like did you try to get copies of
 24 your care plans for days where you had unsatisfactory

Page 227

1 ratings?
 2 A It's possible it's here, like the ones
 3 that I got unsatisfactory.
 4 Q But you don't know?
 5 A No. I'm not for sure.
 6 (Whereupon a brief recess was had,
 7 after which the deposition of
 8 Ms. Marcial continued as
 9 follows:)
 10 MR. LAND: Back on the record.
 11 Q Maricel, if you could look at what's
 12 marked as Exhibit Number 6 to your deposition,
 13 Page 18, you may recall we had looked at this. There
 14 is series of pages here of your typed notes; right?
 15 A Yes.
 16 Q In the third paragraph on this page, near
 17 the end of it there is a reference to Mike Kremer
 18 saying that Ray wanted to meet you and Mike in his
 19 office?
 20 A In Narbone's office. This is after my
 21 meeting with Mike. You are looking at this?
 22 Q That's where I'm looking, yeah.
 23 So there is a sentence that says:
 24 Afterwards he said it would be better if we met with

Page 228

1 Ray today to discuss the plans for my return; right?
 2 A Yes.
 3 Q And you got off the phone; and per their
 4 conversation, Ray wanted to meet us at his office?
 5 A Ray's office, yes.
 6 Q So you went to Ray's office with Mike?
 7 MS. SIEGEL: Where are we?
 8 THE WITNESS: 18.
 9 MR. LAND: Q So there is some bolded language
 10 there and below that it returns to describing what
 11 happened; right?
 12 A Yes.
 13 Q And I believe the paragraph that starts we
 14 arrived at Ray's office and then the paragraph after
 15 that and the one after that, they all describe your
 16 conversation with Ray and Mike in Ray's office; right?
 17 A Yes.
 18 Q And on the next page, all of that page,
 19 the non-bolded words describe your notes about what
 20 was said during that meeting with Ray and Mike as
 21 well; right?
 22 A Yes.
 23 Q And the bolded notes are your commentary
 24 maybe about what happened in that meeting?

5 (Pages 225 to 228)

Page 229

Page 231

1 A Yes.
 2 Q And the following page -- so we're now at
 3 Page 20 -- it also continues. This whole page I think
 4 is more of your notes in the same format about the
 5 conversation with Mike and Ray; right?
 6 A Yes.
 7 Q And the last page, Page 21 is also a
 8 continuation of notes from that meeting; right?
 9 A Yes. Well, this part we had left the
 10 office already; and I think I mentioned here MK
 11 reassures me that in fact he too really is on my side.
 12 It's my commentary. This was in the hallway. He
 13 pulled me aside.
 14 Q So in the middle of Page 18 through the
 15 bottom of Page 20, all of that are notes about your
 16 conversations with Ray and Mike in Ray's office;
 17 right?
 18 A Yes, up to the paragraph before this last
 19 one. At this part we had already left the office, the
 20 last paragraph.
 21 Q The last paragraph on page --
 22 A Page 20.
 23 Q And this all took place on October 24,
 24 2013; is that right?

Page 230

1 A I guess that's what I wrote there.
 2 Q That's what it says there on Page 17?
 3 A Yes.
 4 Q Okay. Would you agree with me that in
 5 your notes about what Ray said to you that there are
 6 many references to clinical issues in your clinical
 7 performance?
 8 A Some references. Others are his opinion.
 9 Q And he was telling you, paraphrasing he
 10 was telling you that he didn't think that you were a
 11 good fit for the program and that coming back would be
 12 something you'd be unsuccessful at; right?
 13 A Yes.
 14 Q That was his opinion?
 15 A Yes.
 16 Q And you had him saying things like, I
 17 don't think you are a fit at all for the program?
 18 A Yes.
 19 Q He said those words to you?
 20 A Yes.
 21 Q He said, You are really pushing the
 22 envelope?
 23 A Yes.
 24 Q He said that?

1 A Yes.
 2 Q He said, It's like you're a square peg in
 3 a round hole? Did he say that?
 4 A Yes.
 5 Q It just does not work. You can't force
 6 it?
 7 A Yes.
 8 Q Okay. And you have those words in quotes
 9 here on Page 18. Are those like verbatim quotes?
 10 A From what I remember him saying right
 11 afterwards. I tried to recall as much as I can that
 12 came from him.
 13 Q When did you write these notes?
 14 A Like that same day. I'm not sure if I
 15 started calling my husband on the phone about that
 16 meeting; and then when I got home, we started
 17 rehashing like the conversations that went on at that
 18 meeting.
 19 Q The order of how you indicate what was
 20 said in that meeting in your notes, is that the order
 21 in which these comments were made during the meeting?
 22 A Pretty much like just recalling because it
 23 was one thing after the other, so I just tried to
 24 recall as many as I can from that conversation; but I

Page 232

1 can't really say that that's the exact order. It
 2 might have the overlapped.
 3 Q Is this your sense of how his comments fit
 4 together, your sense of how that fit together?
 5 A Well, that's what I heard and what
 6 Dr. Kremer had also witnessed. He was there this
 7 whole time.
 8 Q Yeah. I say this because these are your
 9 notes. This is your written record of your memory of
 10 what was said at that meeting; right?
 11 A Yes.
 12 Q I'm wondering if you organized it in ways
 13 that related to how you heard what he said?
 14 A Yes.
 15 Q So after he said those things I was
 16 talking to you about, pushing the envelope, square peg
 17 in a round hole, doesn't work, you can't force it, I
 18 think you indicate that he said, I thought that when
 19 you left you would be coming back in a few weeks
 20 telling us that you were going to drop out of the
 21 program, so I'm surprised to hear that you're still
 22 around; right?
 23 A Yes.
 24 Q After that he told you, I don't think this

6 (Pages 229 to 232)

Page 233

1 plan of yours to be shadowing an anesthesiologists and
2 CRNAs outside of Rush is going to work because the
3 critical decision is theirs, not yours, so it won't
4 help you, and I don't know whose idea this was because
5 it isn't going to help you. Plus, the acuity of cases
6 and standards in those hospitals is not the same as
7 the standards here at Rush.

8 Is that what he told you?

9 A Yes.

10 Q And he said that after he was explaining
11 the square peg in the round hole and you can't force
12 it comments; is that right?

13 A From what I recall.

14 Q Okay. Now, on the next page, the next
15 thing you write that he said is you need to open your
16 eyes and realize this is not a fit for you. Even if
17 you try to apply in other places for nurse anesthesia,
18 it would be difficult or even impossible because they
19 would have to talk to us, and we would have to tell
20 them about your poor performance.

21 So he talked about that?

22 A Yes.

23 Q Referring to your prior poor performance;
24 right?

Page 234

1 A Yes.

2 Q And it's not enough that you wish this,
3 think. Don't let your mind, your heart, or your
4 emotions make this decision because you are just not a
5 fit for this program. There are people who are not
6 meant to do this, so don't force the issue. As an
7 example, there was a child in the OR who was scheduled
8 for an --

9 I don't know what that word is.

10 A Myringotomy.

11 Q -- myringotomy?

12 A Which is an ear -- tympanic membrane hole
13 for pressure relief.

14 Q And ended up having an arrest. Can you
15 imagine taking care of that or being in that
16 situation? And you write, I replied, It certainly
17 sounds overwhelming. Then you say he cuts me off and
18 says, You can't be overwhelmed. You need to be able
19 to act promptly during these stressful situations.
20 Now can you imagine being in charge of this child's
21 life?

22 Right?

23 A Yes.

24 Q So he was explaining those circumstances

Page 235

1 and those ideas to you in that order?

2 MS. SIEGEL: I'm going to object. It calls for
3 speculation.

4 MR. LAND: What's the speculation? These are
5 her notes.

6 MS. SIEGEL: You're asking her what his motive
7 was.

8 MR. LAND: I asked if he explained these ideas
9 to you.

10 A He related --

11 MS. SIEGEL: I'm sorry. Let's get the
12 question.

13 A He made the statements. Like he cited an
14 event.

15 MR. LAND: Q And other things in that
16 paragraph; right?

17 A Yes.

18 Q Like your prior performance and
19 performance issues you had exhibited before; right?

20 A Yes.

21 Q And part of this was him explaining his
22 comments about a square peg in a round hole and it
23 doesn't work and you can't force it?

24 A I don't know if he's seen my evaluations

Page 236

1 to make those descriptions. I think a lot of his
2 statements are from opinions by his CRNAs. He's never
3 told me that he's looked at my evaluations to make
4 that determination that I wasn't fit because before I
5 left I had far more positive evaluations than
6 negatives, and the negatives I've disputed with
7 Dr. Kremer.

8 Q I'm talking about what he said to you and
9 what he was referencing, and he was referencing your
10 evaluations; right?

11 A He didn't say that he referenced it. He's
12 just making an opinion of me.

13 Q He was making reference to your
14 evaluations, wasn't he?

15 A Possibly.

16 Q The next paragraph says: You just don't
17 have the emotional readiness to deal with this kind of
18 thing. You have the smarts, but you don't have the
19 emotional capability for this kind of profession.
20 Your evaluations have been reflective of this.

21 These are your notes talking about what
22 he said. He said those things to you; right?

23 A Yes.

24 Q And you note here that you argued you had

7 (Pages 233 to 236)

<p style="text-align: right;">Page 237</p> <p>1 other evaluations from CRNAs and attendings that gave 2 you positive evaluations more than the negative ones 3 even; right? 4 A Yes. At that time he was just barraging 5 me with all of these insults. I could only say like 6 one sentence before he cut me off again. 7 Q I guess my question is those two 8 paragraphs we just read are referring to clinical 9 assessment meant issues, right, and evaluations and 10 explaining why he thought you were a square peg in a 11 round hole; is that right? 12 A Yes. 13 Q Then the next two paragraphs you reference 14 I think Mike and Ray talking about the idea of you 15 moving on to a different program? 16 A Yes. 17 Q The bottom paragraph on this page says: 18 When you come back, the CRNAs -- You say that Ray said 19 this to you. When you come back, the CRNAs are going 20 to look at you differently; and it's human nature, so 21 I don't have control of how they're going to behave 22 towards you. As a matter of fact, before this 23 meeting, I told one CRNA that I was about to meet with 24 MK and you, and she said, She is not coming back, is</p>	<p style="text-align: right;">Page 239</p> <p>1 Q Then you indicate that Mike said, I 2 actually had a meeting with them this week and they 3 showed their scepticism regarding Maricel's return; 4 right? 5 A Yes. 6 Q And Ray said, See, realize what you're up 7 against. It will be more than an uphill battle for 8 you; and if you made a mistake, it would be looked 9 into with more disdain than when you first committed 10 them. Right? 11 A Yes. 12 Q So is that another example of Ray 13 referring to your prior performance? 14 A Yes. 15 Q And explaining why the CRNAs would look at 16 your current performance differently? 17 A I think it's that plus this cause of my 18 leave altogether, not just my performance. 19 Q Those comments talk about there will be 20 uphill battle if you made a mistake, comparing them to 21 when you first committed them; right? 22 A I guess that's his opinion. 23 Q And he was expressing his opinion to you; 24 right?</p>
<p style="text-align: right;">Page 238</p> <p>1 she? 2 And this comment about how CRNAs are 3 going to look at you differently followed the prior 4 discussion about your clinical performance, right? 5 A That and also being on leave of absence. 6 Q Where does it talk about you being on a 7 the leave of absence in these notes? 8 A Well, this is a check-in during my leave. 9 Q But I'm talking about what he said to you, 10 and I don't think in any of your notes about what he 11 said to you does he reference a leave of absence 12 right? He says when you come back. 13 A Yes, from my leave. 14 Q It doesn't say from your leave; right? 15 A No, but that's the implication. I was on 16 leave during this time, and this is one of the 17 check-ins I had. 18 Q On the next page -- We're at Page 20 now. 19 Are you on the same one with me? 20 A Yes. 21 Q You indicate that Mike -- These are your 22 comments sort of editorializing. Mike stepped in 23 again to elaborate on this theme. Do you see that? 24 A Yes.</p>	<p style="text-align: right;">Page 240</p> <p>1 A Yes. 2 Q His opinion about why the CRNAs would, why 3 it would be difficult for you to succeed in the 4 program; right? 5 A It appears that. 6 Q I'm sorry? 7 A It appears that that's what he's 8 indicating, that they would be more judgmental when I 9 come back. 10 Q And he's saying that they'll be more 11 judgmental because of your prior performance problems; 12 right? 13 A Not only because of that. I think it's 14 also just this forced leave of absence I was put into. 15 Q Where does he say that in your notes about 16 what he said. 17 A Well, when he had run into one of the 18 CRNAs who said, Is she coming back, I hope not, so 19 like factoring in that I was put on leave, plus, you 20 know, referencing some negatives I had. 21 Q He talked a lot about your prior 22 performance, didn't he, and how it would create issues 23 for you? 24 A He mentions the negatives which like I</p>

Page 241

1 said I disputed.

2 Q And then in the next paragraph he's
3 talking about if you make mistakes it will be harder
4 for you to transition to other programs or if you fail
5 out, it will be harder for you.

6 A Yes.

7 Q Right?

8 A Yes.

9 Q So at this point he was trying to talk to
10 you about the decision about when to transfer or when
11 to make that decision?

12 A Yes.

13 Q And then Mike in the next paragraph I
14 think your reference is, that he then asked Mike how
15 many people transfer from their initial program to
16 another program, and Mike indicated that that happens
17 a lot.

18 So again they're talking about
19 transferring; right?

20 A Yes.

21 Q And then you say Ray then refers to my
22 age; and you write here that he said, See, find out
23 where you can be truly successful and be happy there.
24 I don't suppose you are the youngest in the class, so

Page 242

1 why waste your time on something that will make you
2 miserable. Just try to be happy and find that place
3 where you can be a good fit. I'm sorry I've upset
4 you, but you need to hear the truth. The people that
5 are telling you this don't care about you because
6 they're not letting you see your shortcomings, but
7 they're not being honest to you.

8 So the first sentence there, the first
9 two sentences, he's talking about find a place where
10 you can be successful and referencing your age in
11 reference to when to decide to move?

12 A Just saying that I'm -- The way, my
13 impression is he's indicating that I'm the oldest or
14 one of the oldest in my class, not when it's -- So
15 when it's a good time to move, that's not how I
16 interpreted that.

17 Q Is it possible that that's what he meant?

18 A No.

19 MS. SIEGEL: Calls for speculation.

20 MR. LAND: Q Why is that not possible?

21 MS. SIEGEL: Calls for speculation.

22 A I don't know. The way he said it at that
23 time, he seemed very pointed at, you know, you are not
24 the youngest in your class; and it struck a nerve on

Page 243

1 me that you are basically, highlighting my age as a
2 disability for me to succeed in this program.

3 MR. LAND: Q So you don't think it's possible
4 he was talking about when you should decide to
5 transfer?

6 A No.

7 Q Isn't that what he was talking about
8 leading up to making that comment?

9 A No. That's not how I received it.

10 Q That's not what I asked really. I asked
11 what he was talking about before he made that comment,
12 and the paragraphs just prior have him talking about
13 transitioning and when to do that; right?

14 A No, because if you transition to a
15 different program like he mentions further down here,
16 you'd have to get their permission or the reference to
17 go to that program. So even if I've finish my
18 didactics, it's still up to them to make that
19 discretion of giving me a good reference to transition
20 to a different program.

21 So I recognize that what he's saying
22 here is really not the optimal timing of me to
23 transition to a different program but that, you know,
24 he just was indicating I'm not the youngest in my

Page 244

1 class. Age was a factor.

2 Q I asked you about what he said. You
3 talked about didactics and other things which he
4 didn't talk about with you at all.

5 What I'm asking is hadn't he just
6 talked to you about transitioned timing and doing it
7 before you fail out? Isn't that what the notes show,
8 how it would be easier to do that instead of waiting
9 until you fail out later? Isn't what he's saying?

10 A Yes.

11 MS. SIEGEL: I'm going to object. The witness
12 has indicated and you asked and the testimony has
13 established that these comments are not necessarily in
14 the order in which they are were delivered.

15 MR. LAND: What kind of objection are you
16 making now outside from coaching her about what to
17 say?

18 MS. SIEGEL: I'm not coaching her about
19 anything.

20 MR. LAND: I didn't hear any form of objection.
21 I heard you saying many words telling her what to say.
22 I would prefer that you not do that.

23 MS. SIEGEL: I did not do that, and she
24 answered the question while I was pointing out that

<p style="text-align: right;">Page 245</p> <p>1 one of the first questions that you asked -- and she 2 can step out of the room if you want me to make the 3 objection so she doesn't hear it. I'm not coaching 4 her. But what I'm saying -- Do you want me to do 5 that? 6 MR. LAND: No. I don't want you to do that. 7 I would like you to let me ask her questions. 8 MS. SIEGEL: I want my objection on the record. 9 First of all, you established that the comments -- 10 MR. LAND: This is not an objection. This is 11 you testifying. 12 MS. SIEGEL: I'm not testifying, and like I'd 13 to make this objection. 14 And I would like you to go out of the 15 room so that I am not accused of coaching you because 16 I don't do that. 17 (Whereupon the witness exited the 18 room.) 19 One of the first things that you did 20 was that you established that this wasn't necessarily 21 in the order, this -- I'm point to the document -- 22 that the comments were not necessarily in the order 23 that they were stated at the meeting but that she had 24 grouped them according to her understanding of the</p>	<p style="text-align: right;">Page 247</p> <p>1 MR. LAND: Q Did Ray Narbone comment about you 2 not being the youngest person in your class follow 3 what he asked you about or talk to you about your 4 transition timing. 5 A To the best of my recollection, yes. 6 Q But you don't think that that was related 7 to the transition timing? 8 A No. 9 Q And you think that it's not possible that 10 that's what he meant? 11 A No. 12 Q Why not if they were next to each other in 13 the way that he communicated to you? 14 A I just feel that he wanted to point at 15 that age factor a lot and my success in the program 16 and that to soften the blow, transition to or offer 17 this consolation that I could be transitioned. That's 18 how I received it then. 19 Q Did Ray Narbone evaluate your performance 20 in the program? 21 A No. 22 Q This comment he made about I don't suppose 23 you're the youngest in your class, is that the only 24 comment he made about your age?</p>
<p style="text-align: right;">Page 246</p> <p>1 topics 2 MR. LAND: And how did that fit together which 3 is what she said in her mind. 4 MS. SIEGEL: Right. And now you're saying, 5 well, didn't he talk about this age discrimination 6 right after talking -- I'm sorry, the reference to the 7 age right after talking about the transfer into other 8 programs. 9 MR. LAND: Those are not mutually exclusive 10 things. 11 MS. SIEGEL: Sure they are. 12 MR. LAND: No. They're not. If two comments 13 happen to be next to each other, they might be 14 sequential. 15 MS. SIEGEL: Your question assumed that. You 16 didn't establish that. If you want to ask it 17 correctly, I don't have any objection to it. 18 MR. LAND: The objection you're raising is 19 what? Is it the form of the question that's wrong? 20 MS. SIEGEL: It assumes a fact not in evidence. 21 MR. LAND: Okay. Thank you. 22 MS. SIEGEL: You are welcome. 23 (Whereupon the witness entered the 24 room.)</p>	<p style="text-align: right;">Page 248</p> <p>1 A From the best of my recollection, yes. 2 Q What does that mean? 3 A Yes. That's all I can recall him 4 referring to my age. 5 Q Did Ray Narbone say anything about your 6 national origin or race during this meeting? 7 A No. 8 (Marcial Deposition Exhibit No. 8 9 was marked for identification.) 10 Q Do you recognize what's been marked as 11 Deposition exhibit Number 8, Maricel? 12 A Yes. 13 Q What is it? 14 A It's my student learning contract in 15 preparation for my return in the spring or in January. 16 Q Did you sign this document? 17 A Yes. 18 Q Does this document create an outline of 19 your expectations, your work, your learning objectives 20 when you return? 21 A Yes. 22 Q And was this a follow-up to the fact that 23 you had left the program when you were on probation? 24 A Yes.</p>

Page 249

1 Q So part of the reason to have this
2 learning contract with its expectations and objectives
3 for you was to make sure that Rush was following up on
4 those prior problems; is that right?

5 A I think this is just a general expectation
6 of any SRNA because most of this was lifted from the
7 student, the SRNA handbook.

8 Q You are saying that these don't contain
9 any different obligations for you than other SRNAs?

10 A Except for the one-to-one CRNA, this is
11 pretty much the expectation for us in the residency.
12 It's the same as what would be expected of my
13 classmates except the one-to-one CRNA and this
14 clinical skills simulation. So the action plan is
15 different, but the rest is pretty much the same
16 expectations as my classmates.

17 Q So it starts by saying the identified
18 problem. Do you see that at the top?

19 A Yes.

20 Q And it references faculty members'
21 expressions of concerns about your ability to provide
22 anesthesia care without constant CRNA supervision;
23 right?

24 A Yes.

Page 250

1 Q So that's different than most SRNAs;
2 right?

3 A Yes.

4 Q And then under the action plan it requires
5 you to execute this learning contract; right?

6 A Yes.

7 Q And that's different than most SRNAs;
8 right?

9 A Well, there is a difference in this
10 portion.

11 Q It also says you agree to weekly meetings
12 with a program director to review clinical progress.
13 Is that different?

14 A Yes. It's different.

15 Q You said that the one-on-one CRNA
16 supervision in the OR on a general rotation until
17 further notice, you said that that was different?

18 A Yes, because at that point I've already
19 had like three months I think of residency. So coming
20 back on one to one again, it different from my
21 classmates at that point in training. Like they're
22 not one to one anymore is what I meant.

23 Q If you move on to criteria for
24 achievement, it lists: Be prepared for assigned cases

Page 251

1 each day. Do you see that?

2 A Yes.

3 Q And then after that it says failure to be
4 adequately prepared for each day will result in
5 dismissal from the clinical area for the day. Do you
6 see that?

7 A Yes.

8 Q Is that different than other SRNAs?

9 A No.

10 Q That's the same?

11 A Yes. They're all expected to come in
12 prepared and ready to provide anesthesia.

13 Q Under patient safety, it says: The
14 student will consistently attain satisfactory scores
15 in this category of the formative evaluation. Failure
16 to consistently obtain satisfactory scores and
17 criteria related to patient safety will result in a
18 grade of no pass for NRS 600 PA. Was that the same as
19 other SRNAs?

20 A This looks familiar in the sense of what
21 the student handbook tells us to read as part of our
22 residency or as part of our being in clinicals. So
23 this was lifted from the student handbook. So it's
24 expected from each SRNA.

Page 252

1 Q So this sounds a little different than --
2 I don't see anywhere in this learning contract to any
3 reference to a verbal warning for one unsatisfactory
4 rating, a written warning for another, right, that you
5 had discussed previously with Mike Kremer?

6 A Yes. It doesn't seem to stipulate that.

7 Q In the evaluation section at the end, it
8 indicates that you would need a minimum of 28
9 formative evaluations to be submitted for the academic
10 term; right?

11 A Yes.

12 Q And that you'd meet with a program
13 director weekly to review formative evaluations?

14 A Yes.

15 Q Then it goes on to indicate that you'd
16 need to have ratings in the areas of patient safety,
17 psychomotor skills, clinical judgment and
18 professionalism, most consistently be satisfactory for
19 the student to attain a passing grade in NRS 600 PA;
20 right?

21 A Yes.

22 Q So this was designed to set up the terms
23 for your return?

24 A Yes.

11 (Pages 249 to 252)

Page 253

1 Q Were you coming back at the beginning of
2 the residency?

3 A I was told during our meeting -- When I
4 signed this contract, I was meeting with Dr. Johnson
5 and Dr. Kremer; and I had asked, Am I being given a
6 fresh start which is basically a do over from my
7 residency that started in like late May or June. So
8 my understanding was it's a fresh start for my
9 residency.

10 Q Meaning what?

11 A That I'm not going to be treated as
12 expertly or the way -- I'm not going to be graded the
13 way my classmates who have not had any interruption in
14 their training, the same way.

15 Q They said that to you?

16 A I asked, Are you guaranteeing that I will
17 get a fresh start because, as you know, I have not
18 been exposed to any clinicals for about five months.
19 So if my grading system is gauged against us, another
20 student, one of my classmates who's never had any
21 interruption, then I don't think it would be fair to
22 expect of me their level of skill as opposed to mine
23 when I come back when I haven't been exposed for five
24 months.

Page 254

1 Q When you say your classmates, do you mean
2 the members of your cohort who had started with you?

3 A Yes.

4 Q Who had started residency with you in the
5 spring of 2013?

6 A Yes, because we had like -- Back then it
7 wasn't residency yet. Residency started late May or
8 June.

9 Q I don't think you are saying that they
10 said they would ignore that you had unsatisfactory
11 ratings before?

12 A No.

13 Q Is that right?

14 A Yes.

15 Q So the prior unsatisfactory ratings were
16 still relevant to evaluation of your work?

17 A Yes.

18 Q Did you complain about discrimination at
19 this meeting with, is it, Mary Johnson and Mike
20 Kremer?

21 A Yes.

22 Q You did?

23 A Yes.

24 Q Is that the meeting you recorded?

Page 255

1 A Yes.

2 Q Without telling them that you were doing
3 that?

4 A Yes.

5 Q What did you say about discrimination in
6 that meeting?

7 A I mentioned that I'd like to revise this
8 contract to add that if there are any discriminatory
9 treatments towards me that there should be oversight
10 to recognize that or to correct that.

11 Q They didn't agree to that?

12 A Dr. Kremer said no; and then Dr. Johnson
13 said, How do you gauge that, that they are
14 discriminating? And I said, Aren't you supposed to
15 set the standard also to be advocates of the students?
16 So I turned it to them to give me sort of like or to
17 have a sense of accountability for the faculty to be
18 fair to students in general.

19 Q Did they agree that the faculty should be
20 fair?

21 A Yes.

22 Q Did you say bias to them or
23 discrimination?

24 A I think I mentioned bias, the term bias;

Page 256

1 and I might have mentioned -- I might have said
2 discrimination, but that was my thought process then.

3 Q Discrimination on the basis of what did
4 you say to them?

5 A I didn't elaborate on it, but I just said
6 like I'd like to make sure that there is oversight if
7 I felt like I'm being discriminated or biased upon by
8 the faculty.

9 Q So did you tell them that you thought you
10 had been discriminated against in the past at that
11 meeting?

12 A No. From my understanding Dr. Kremer was
13 aware, and he had been meeting with Dr. Johnson
14 routinely; so I had an understanding that she knew
15 what was going on.

16 Q With respect to things you had said about
17 feeling that you had been discriminated against?

18 A To Dr. Kremer, yes.

19 Q When did you tell Dr. Kremer what you
20 thought you were discriminated against?

21 A I think in some of our meetings leading up
22 to my leave of absence. I'm not sure which -- I met
23 with him maybe four, five times then; so I mentioned
24 that to them, to him.

12 (Pages 253 to 256)

<p style="text-align: right;">Page 257</p> <p>1 Q Discrimination on the basis of what did 2 you tell him you thought you were suffering? 3 A I just said that I feel like I'm getting 4 discriminated upon, and I might have mentioned racial 5 to him. 6 But also I mentioned that the pattern 7 of treatment that I'm receiving is indicating that 8 compared to my white cohorts there is definitely a 9 disparity in our treatment. That's what I remember 10 mentioning to Dr. Kremer. 11 Q In what way did you say there was 12 disparity in your treatment compared to white cohorts? 13 A So I mentioned that certain times -- For 14 example, I had missed maybe a history or an item in 15 the preoperative sheet of a patient, and I would be 16 ranked non-satisfactory for that minor detail whereas 17 another white cohort of mine had missed two crucial 18 cardiovascular histories. 19 And I reported it to our CRNA then. 20 I believe it was Kathleen Uremovic, and she didn't 21 blink an eyelash. She didn't make anything out of it 22 as far as I know. She wasn't reprimanded for that 23 misstep. 24 And also, you know, missing an IV, I</p>	<p style="text-align: right;">Page 259</p> <p>1 A In the evaluations; and sometimes we don't 2 necessarily have to hand an evaluation to, you know to 3 every CRNA, but some of them actively get it and write 4 me up for some things which I've noticed that my other 5 classmates don't really sometimes experience that. So 6 I'm just trying to recall like the -- 7 Q I'm hearing you talk about evaluations. 8 A Yes, evaluations. 9 Q Written evaluations that you thought were 10 different for you than others? 11 A Yes. 12 Q Based on race? 13 A Yes. 14 Q Is there anything else you thought that 15 you told Mike that you thought was discriminatory in 16 the way you were treated besides written evaluations? 17 A I don't recall like everything offhand, 18 but that's mostly what I told him. 19 Q And you told us last time -- but I don't 20 remember -- you haven't seen very many other students' 21 written evaluations; right? 22 A Some of them we have compared, yeah, but 23 not a whole lot. 24 Q At the time you hadn't seen --</p>
<p style="text-align: right;">Page 258</p> <p>1 would get dinged for it whereas another student, 2 somebody else I would be paired with sometimes would 3 miss IVs and be witness but not be dinged for it or 4 they don't get unsatisfactory for that. 5 So some things are glossed over when 6 some of my classmates are getting evaluated as 7 compared to my shortcomings. It never escapes their 8 scrutiny. 9 Q That's what you said to Mike in one of 10 those meetings leading up to your leave of absence, 11 that you thought you were discriminated against 12 because you got unsatisfactory ratings for things that 13 your white cohorts did but they didn't get the same 14 ratings? 15 A Yes. 16 Q Is there anything else you told them you 17 thought was discriminatory besides evaluations? 18 A I told him that it seems like their 19 pattern of criticizing me or scrutinizing me is much 20 more harsh compared to my cohorts sometimes. I'm just 21 trying to recall. 22 Q When you say you told them that their 23 pattern of criticism and scrutiny was harsh, more 24 harsh, you mean in the evaluations themselves?</p>	<p style="text-align: right;">Page 260</p> <p>1 A Yes. At the time, yes. 2 Q And you said that you might have mentioned 3 race as the basis for discrimination to Mike. Does 4 that mean you might not have? 5 A I might have alluded to it. So I had like 6 several meetings with him and sometimes not in person 7 or in his office meetings. Sometimes like after a 8 class in the hallway, in between class breaks I've 9 talked to him. So in one of those conversations I 10 might have referred to it. 11 Q And you might not have referred to race? 12 A No. I'm sure I referred race to him. 13 Q You but don't know what meeting it was? 14 A No. I don't. 15 Q Was it one meeting where you referred to 16 race you think? 17 A It could have been, yeah, one meeting. 18 Q You don't know? 19 A No. I don't. 20 Q So you don't know when it was and you 21 don't know if you said it more than once before your 22 leave of absence? 23 A Yes, because of a lot of things -- We 24 talked about a lot of things, and so it's from what I</p>

Page 261

1 remember.

2 Q And before your leave of absence, did you
3 talk to anyone else at Rush and tell them you thought
4 you were being treated differently on the basis of
5 your race?

6 A My classmates.

7 Q Anyone who worked at Rush?

8 A I think I might have mentioned -- I'm not
9 sure if I happened to mention it to Dr. Terrebossy.

10 Q Your therapist?

11 A Yes, the counselor, the school counselor.

12 Q Anyone else at Rush who you think you
13 might have mentioned it to, race before your leave of
14 absence?

15 A I'm not sure if we -- Well, I saw
16 Dr. Halsted after my leave. So I think that's pretty
17 much from what I can remember. That's it that I can
18 remember.

19 Q Okay. And after you went on leave, did
20 you tell anyone else at Rush that you thought that you
21 were subjected to race discrimination?

22 A I think it was mostly Dr. Kremer and
23 Shannon Shumpert at HR when I returned from my leave.

24 Q That was in the spring of 2014 that you

Page 263

1 Q Do you know if they had progressed further
2 in their residency in terms of independence than you
3 had?

4 A No.

5 Q So they might have?

6 A Well, we have an Excel spread sheet of
7 where our rotation is supposed to be; and we all start
8 in general rotation in June. That's the first
9 month --

10 Q In May; right?

11 A -- of our residency. In June I think?

12 Q Didn't Jill Wimberly evaluate you May 10
13 of 2013?

14 A That was before residency.

15 Q It was?

16 A That was still part of our didactics.

17 Q When did your residency start?

18 A As far as I know, the last week of May or
19 the first week of June because we had a break from,
20 you know, finishing didactics. Then we had a
21 three-week break, and then we start on to residency.

22 Q You're saying that you believe that three
23 of your classmates were allowed to work without
24 one-on-one supervision in early June?

Page 262

1 complained to Shannon Shumpert?

2 A Yes.

3 Q Did you do that in writing?

4 A In person, and I think we followed up by
5 email.

6 Q Before you went on your leave of absence,
7 did you ask to be allowed to work at a different
8 neutral location instead of at Rush?

9 A Yes.

10 Q Do you know if students were allowed to do
11 that if they were not past the stage of one-on-one
12 CRNA supervision?

13 A Yes.

14 Q How do you know that?

15 A Because I went to one of the Oak Park
16 orientations around June, and we were still one-on-one
17 then. I had seen three of my classmates work there,
18 Michelle Becka, Ashley Essig, and Kelly Palmer.

19 Q You said July 1st?

20 A No, around June.

21 Q June 1st.

22 A I think it was a couple, the first couple
23 weeks of June. It probably is in one of the emails
24 when I was sent there to have orientation.

Page 264

1 A Well, it was a neutral site. I'm not sure
2 if they were still one-on-one supervision there. It
3 was an off site.

4 Q Do you know if there have been students
5 with multiple unsatisfactory ratings that are allowed
6 to work at a different location than Rush?

7 A Well, there is a couple of places, MacNeal
8 and Cook County where I'm the only one who didn't go
9 there; but the rest of my classmates who in talking to
10 them later have also had unsatisfactories were sent to
11 MacNeal and Cook County, and those two hospitals are
12 required one-to-one supervision.

13 Q How do you know that those two hospitals
14 required one-to-one supervision?

15 A There was an email by Dr. Kremer to the
16 class saying -- Well, first it started off that it has
17 come to his attention that students are complaining
18 about the CRNAs they are being paired with; and then
19 he mentions later on that don't feel that this is a
20 regression of your skills, something to that effect or
21 that kind of theme. Don't think this is a regression
22 to your skills, but when you go to MacNeal and Cook
23 County, you are going to be required to be overseen
24 one to one by the CRNAs there.

14 (Pages 261 to 264)

<p style="text-align: right;">Page 265</p> <p>1 Q You said that there were people that you 2 knew who were assigned to MacNeal and Cook County who 3 had unsatisfactory ratings? 4 A Uh-huh, yes. 5 Q Who were those people? 6 A I believe Ebele and Karen. They had 7 mentioned they have had their own shares of 8 unsatisfactories, but we all at some point were 9 scheduled to rotate in those facilities. 10 Q I understand. I just want to understand 11 who you are saying you knew had unsatisfactory ratings 12 but were allowed to be assigned to MacNeal and Cook 13 County. You said Ebele and Karen? 14 A Ed Gradman (phonetic) had 15 unsatisfactories, but he had chosen to go to Cook 16 County. So not all of us actually would choose to go 17 to Cook County. 18 So I'm talking in terms of MacNeal. 19 I think Karen and Ebele went there. Ed, he chose to 20 go to Cook County; but he's had previous 21 unsatisfactories which what we have heard, yeah. 22 Q How many unsatisfactory ratings did Ebele 23 have? 24 A I don't know.</p>	<p style="text-align: right;">Page 267</p> <p>1 have some of her clinicals off site. 2 Q While she was on probation? 3 A Yes. 4 Q Did anyone tell you the reason you 5 wouldn't be assigned to another location was because 6 you needed to have one-on-one supervision in light of 7 your unsatisfactory ratings or performance? 8 A No. They just said in general that 9 problem students -- because I asked Dr. Wiley why 10 can't I be sent off-site, and her only response was 11 problem students have to come back to the university. 12 Q Do you know if that's true? 13 A No, because, like I said, I've seen three 14 of my classmates go there as beginners in an off-site 15 facility. 16 Q Were they problems? 17 A I have never talked to them about their 18 evals. 19 Q Yeah. That's what I'm asking you is. Do 20 you know if it's true that students who are considered 21 problems, students who are considered to have 22 problematic clinical experiences are not allowed to be 23 sent away from Rush? 24 A Like I had mentioned, Faith, she has had</p>
<p style="text-align: right;">Page 266</p> <p>1 Q How many did Karen have? 2 A She mentioned three, but she didn't say 3 all of it. 4 Q How many did Ed have? 5 A I think I know of two just overhearing one 6 of the CRNAs I think who graded him. Yeah. That's 7 all. I'm not sure. 8 Q Do you know if their unsatisfactory 9 ratings were for reasons that were as severe as what 10 people wrote down about what your unsatisfactory 11 ratings were for? 12 A We didn't discuss in detail what they 13 were. 14 Q So you don't know; right? 15 A No. 16 Q Was it explained to you why you wouldn't 17 be assigned to work at another location? 18 A The only answer I was given was problem 19 students need to return to the main hospital. 20 Q Do you know anyone who was put on an 21 academic improvement plan who was assigned to work at 22 another location? 23 A Yes, from another cohort, Faith Bloomer 24 who was on probation twice, but she was allowed to</p>	<p style="text-align: right;">Page 268</p> <p>1 problematic histories, but she was allowed to go off 2 -site. 3 Q Is there anyone else you know of who was 4 allowed to do that? 5 A No, no. I'm not sure. 6 Q Isn't there a sense of for patient safety 7 purposes it could make sense for an SRNA program to 8 want students who have had problems in clinicals to be 9 kept somewhere where people can evaluate them 10 carefully? 11 MS. SIEGEL: Calls for speculation. 12 A No. 13 MR. LAND: Q No? 14 A I don't think that that's the main thing 15 because -- Well, I guess from my observation when I'm 16 being paired with my other cohorts that I am surprised 17 that they are allowed to go off even though their 18 skills are not up to par from, you know, my 19 observations. So I don't know. I don't know what 20 their standards are or by what measure they gauge it. 21 Q You thought there were other students that 22 you didn't think were very good who were allowed to go 23 somewhere else; is that what you just said? 24 A Yes.</p>

<p style="text-align: right;">Page 269</p> <p>1 Q From your own observation of evaluating 2 their work? 3 A And like comments that CRNAs, we overhear. 4 Q Did you think you were qualified to 5 evaluate how far along other SRNAs were in their 6 abilities? 7 A No. 8 Q When you were go going to return in 2014, 9 was it your understanding that you would need to get 10 evaluations from CRNAs for everything that you did? 11 A It was suggested that I give daily 12 evaluations. 13 Q Who suggested that? 14 A Dr. Kremer. 15 Q Was that requirement for you? 16 A No. 17 Q Explain to me how if the director of the 18 program makes a suggestion to you don't take that as a 19 requirement? 20 A Because it's not in my learning contract 21 and it's not in the student policy. It says there 22 what's required of second-year residency students in 23 the student policy, that we just need to have 28 24 evaluations at the end of the quarter.</p>	<p style="text-align: right;">Page 271</p> <p>1 was that Mike told you he would seek to limit your 2 exposure to Jill Wimberly and Eva Fisher? 3 A Yes. 4 Q But not eliminate exposure to them; right? 5 A Yes. 6 Q So was it your understanding that it would 7 be fair for you to be assigned to Jill Wimberly or Eva 8 Fisher as a CRNA? 9 A Was it my understanding that it would be 10 fair? 11 Q Yeah. 12 A No. I expected that I wouldn't be 13 assigned with them again because I had expressed my 14 concern of their biased evaluations of my work. 15 Q But no one had promised that to you; 16 right? 17 A No. 18 Q Mike had said he would try to limit it as 19 much as he could; right? 20 A He said, I will try not to pair you with 21 her. He didn't say limit. He just said, I will try 22 not to look at you. 23 Q Should we look at the notes of what you 24 told your counselor, Terrebossy?</p>
<p style="text-align: right;">Page 270</p> <p>1 Q Did Mike Kremer follow up with you after 2 you started asking you to make sure that you turn in 3 evaluations? 4 A On occasions. 5 Q Did you avoid getting evaluations from 6 CRNAs in some cases when you first started? 7 A Not initially. 8 Q I don't understand. Does that mean that 9 you got evaluations from every CRNA when you started? 10 A Yes. Some of them didn't return it; and 11 Dr. Kremer told me, Make sure you follow up with that 12 CRNA, and I did; and they still didn't return it. So 13 that's all we could do it is give it out. 14 Q When you met with Dr. Kremer and Mary 15 Johnson, did you talk at all about who you would be 16 assigned to work with, CRNAs? 17 A I think I had mentioned -- I'm trying to 18 recall if it's at that meeting. I think, you know, we 19 just mostly talked about the learning contract. I 20 don't recall that we talked about which CRNAs I'd like 21 to be assigned to. 22 Q In your notes with your Counselor 23 Terrebossy that we went over in your first deposition, 24 there was reference to you telling her that the plan</p>	<p style="text-align: right;">Page 272</p> <p>1 A Sure. 2 Q Are you sure he didn't say he would limit 3 it? 4 A He might have. 5 Q Because that's what you testified to 6 before. That's why I'm asking you. 7 A Sure. I guess, sure. 8 MS. SIEGEL: Why don't you pull it out so she 9 can see it. 10 MR. LAND: Q I'm just not sure that you know. 11 Do you know what he said to you about what was 12 expected when you came back on that issue? 13 A From what I recall, he said, We will try 14 not to pair you with her. 15 Q Which meant you could be paired with her? 16 A I could be, but I know that other students 17 who have requested that of him were never paired again 18 to the CRNAs they complained about. So my expectation 19 was he was going to follow through with that same 20 promise to me. 21 (Marcial Deposition Exhibit No. 9 22 was marked for identification.) 23 Q Exhibit 9, Maricel, is a series of emails 24 between you and Mike Kremer dated January 17 and 19;</p>

Page 273

1 is that right?

2 A Yes.

3 Q 2014?

4 A Yes.

5 Q And it's related to clinical evaluations:

6 Right? That's the subject line?

7 A Yes.

8 Q In the first email which is at the bottom
9 of the page, isn't he indicating he has not received
10 evaluations from you and some, in fact, they reported
11 that you have not given them evaluations to complete?

12 A Yes.

13 Q Was that true, that you hadn't given
14 evaluations to some faculty to complete?

15 A I think there were a couple of faculty
16 that I didn't give it to.

17 Q Why didn't you?

18 A The first evaluation, what I recall was I
19 was assigned to Angela twice; and the first one was
20 just full of misrepresentations. So my sense was she
21 wasn't going to evaluate me fairly, and so I tried --
22 I decided for my own benefit and also to try to save
23 my skin basically is to get somebody who is more fair
24 and honest with their appraisal of me.

Page 274

1 Q The next paragraph starts: Per my text
2 messages to you this week, you must distribute
3 evaluations to CRNAs you work with each day.

4 Had he sent you text messages saying
5 that?

6 A I don't recall. I think the text messages
7 I have gotten from him were either like when we're
8 going to schedule a meeting at the end of the week.
9 I don't recall like the texts that he sent me.

10 Q Then two sentences later it says: If you
11 do not submit formative evaluations, you will not be
12 assigned to cases in the OR since we need this
13 feedback to evaluate performance.

14 Is that a requirement?

15 A I guess he's indicating that, but I still
16 got sent -- I still got assigned to the OR, so I don't
17 know if after that he started getting the evaluations
18 that I've handed to some of the CRNAs.

19 Q So I asked if that's a requirement and,
20 I'm not sure you explained whether it is or it isn't.

21 A I don't think so.

22 Q The email he writes to you at the top of
23 this page --

24 A Yes.

Page 275

1 Q -- has a sentence that says, You must
2 distribute evaluations each day. I cannot keep you in
3 the clinical area without formative evaluation
4 feedback. Is that a requirement?

5 A That's what he suggests to me, but I don't
6 find that as a requirement since it's not in my
7 learning contract and it's not in the student
8 handbook. So why am I going to have to a different
9 requirement compared to my cohorts.

10 Q Maybe because you had a series of
11 unsatisfactory ratings and they were worried about
12 patient safety?

13 A Just like my other classmates who have had
14 also negatives that held back.

15 MR. LAND: Let's mark another exhibit.

16 (Marcial Deposition Exhibit No. 10
17 was marked for identification.)

18 Q Did you receive this email from
19 Mike Kremer dated January 20, 2014 about clinical
20 assignments?

21 A Yes.

22 Q In it he's indicating that he had never
23 told you that your clinical assignments would exclude
24 any members of the anesthesia department; right?

Page 276

1 A Yes.

2 Q Is that true?

3 A When I met with him, I disputed that.
4 I told him, You said you weren't going to pair me with
5 her again; and he answered back, That was then. This
6 is now. You can't possibly avoid every single CRNA.
7 I said, I'm not trying to avoid every single one of
8 them. I'm asking one person, to one person not to be
9 assigned. So I disputed this in person with him in
10 one of our meetings.

11 Q So I have to say I'm confused. You've
12 testified several times in different ways about what
13 Mike Kremer told you about whether you would assigned
14 to CRNAs including Jill Wimberly and Eva Fisher. What
15 did he actually tell you when you were talking about
16 coming back; do you know?

17 A Well, like I said, when I had this meeting
18 with him and Dr. Johnson, we didn't discuss a specific
19 CRNA that I wasn't going to assigned to. I still had
20 the understanding that before my leave when he said we
21 will limit or try to avoid pairing you with Jill that
22 that promise was still effective when I came back from
23 my leave.

24 Q The promise to try to avoid pairing you

<p style="text-align: right;">Page 277</p> <p>1 with Jill?</p> <p>2 A Yes.</p> <p>3 MS. SIEGEL: It's a little after 3:00. Why</p> <p>4 don't we take a little time here.</p> <p>5 MR. LAND: Okay.</p> <p>6 (Whereupon a brief recess was had,</p> <p>7 after which the deposition of</p> <p>8 Ms. Marcial continued as</p> <p>9 follows:)</p> <p>10 (Marcial Deposition Exhibit No. 11</p> <p>11 was marked for identification.)</p> <p>12 MR. LAND: Q Do you recognize Exhibit</p> <p>13 Number 11, Marciel?</p> <p>14 A Yes.</p> <p>15 Q Did you write this document?</p> <p>16 A I put it together.</p> <p>17 Q It's entitled Response of Marciel Marcial</p> <p>18 to Evaluations between January and March, 2014; right?</p> <p>19 A Yes.</p> <p>20 Q You said you helped put it together?</p> <p>21 A Well, I didn't write it. I just added.</p> <p>22 Q Who helped you?</p> <p>23 A My husband.</p> <p>24 Q If you could turn to Page 5 of this</p>	<p style="text-align: right;">Page 279</p> <p>1 by Jim Miller on the 17th and the other by Renee</p> <p>2 Przygodzlek on the 24th.</p> <p>3 Q So it seems to be saying that the January</p> <p>4 20th was the turning point?</p> <p>5 A It's saying that it's a stark difference</p> <p>6 from my other evaluations, like right in the middle.</p> <p>7 This is the 20th? Yeah.</p> <p>8 Q So was it your idea that it would be a</p> <p>9 good idea to compare evaluations before January 20 and</p> <p>10 those after? It says: It is worth comparing here the</p> <p>11 evaluations before and after this day; right?</p> <p>12 A Yes.</p> <p>13 MR. LAND: Let's mark this.</p> <p>14 (Marcial Deposition Exhibit No. 12</p> <p>15 was marked for identification.)</p> <p>16 Q So if you could keep Exhibit 11 available</p> <p>17 to you --</p> <p>18 A Yes.</p> <p>19 Q -- but let's look at Exhibit Number 12</p> <p>20 right now. Exhibit 12 I'll represent to you is a</p> <p>21 compilation of --</p> <p>22 MS. SIEGEL: I'm sorry. Am I missing -- Oh, I</p> <p>23 got them mismarked. So the response is DX 11?</p> <p>24 MR. LAND: Yes.</p>
<p style="text-align: right;">Page 278</p> <p>1 document, near the bottom there is a reference to Jill</p> <p>2 Wimberly on January 20, 2014. Do you see that?</p> <p>3 A Yes.</p> <p>4 Q And the third bullet under that evaluation</p> <p>5 day, this document explains your response to various</p> <p>6 evaluations of you during this time period, right,</p> <p>7 January to March, 2014?</p> <p>8 A Yes.</p> <p>9 Q And it references this evaluation day with</p> <p>10 Jill Wimberly of January 20, 2014; right?</p> <p>11 A Yes.</p> <p>12 Q The third bullet there says: Evaluations</p> <p>13 from that day were nearly exclusively ones with a</p> <p>14 small number of twos. Per Dr. Kremer, a score of</p> <p>15 "one" renders an entire evaluation as unsatisfactory.</p> <p>16 It is worth comparing here the evaluations before and</p> <p>17 after this day from different CRNAs; right?</p> <p>18 A Yes.</p> <p>19 Q So are you suggesting here that Jill</p> <p>20 Wimberly had an impact on CRNA evaluations of you in</p> <p>21 2014?</p> <p>22 A No. I'm suggesting that this is such a</p> <p>23 stark difference in how I was evaluated compared to</p> <p>24 two different CRNAs who evaluated me positively, one</p>	<p style="text-align: right;">Page 280</p> <p>1 Q Exhibit 12 is a compilation of evaluations</p> <p>2 of you from January of 2014 through May of 2014.</p> <p>3 Okay?</p> <p>4 A Yes.</p> <p>5 Q So the first one is dated January 9th,</p> <p>6 2014; right?</p> <p>7 A Yes.</p> <p>8 Q Who is that from?</p> <p>9 A Kathleen Oskvarek.</p> <p>10 Q Does that contain an unsatisfactory rating</p> <p>11 for you?</p> <p>12 A Yes.</p> <p>13 Q A one for performs complete preoperative</p> <p>14 assessment?</p> <p>15 A Yes.</p> <p>16 Q And then in her notes she writes some good</p> <p>17 comments about good job with intubations and IVs?</p> <p>18 A Yes.</p> <p>19 Q Then I think it says: Be cautious with --</p> <p>20 What does that say?</p> <p>21 A Preops, preoperative. Missed abnormal</p> <p>22 EKG.</p> <p>23 Q Did you miss an abnormal EKG that day?</p> <p>24 A There was a comment on the bottom that I</p>

Page 281	Page 283
<p>1 had missed, yes.</p> <p>2 Q Did you miss an abnormal EKG that day?</p> <p>3 A Not during the case, just on that one</p> <p>4 document that we were reviewing all of this files of</p> <p>5 patients' histories. That's the one she was referring</p> <p>6 to.</p> <p>7 So there was an EKG. The diagnosis was</p> <p>8 on top; and on the bottom there was a comment, I think</p> <p>9 second-degree AV block, and the patient wasn't in that</p> <p>10 rhythm. So that's what she was referring to, that one</p> <p>11 item of the multiple documents that we had to review</p> <p>12 on this patient.</p> <p>13 But in terms of the actual performance</p> <p>14 in the surgery, there were no instances that I missed</p> <p>15 an EKG.</p> <p>16 Q Isn't this rating you unsatisfactory for</p> <p>17 your clinical judgment in performing a complete</p> <p>18 preoperative assessment?</p> <p>19 A Yes.</p> <p>20 Q And that happened; right?</p> <p>21 A Yes.</p> <p>22 Q Because you missed an abnormal EKG in the</p> <p>23 preoperative assessment; right?</p> <p>24 A Yes.</p>	<p>1 right now, but if you follow the next several pages,</p> <p>2 it goes through a series of other evaluations you had?</p> <p>3 A Yes.</p> <p>4 Q And I don't see a reference to the</p> <p>5 evaluation by Kathleen Oskvarek in this either.</p> <p>6 A Yeah. I don't think I made one. I didn't</p> <p>7 do a rebuttal on this.</p> <p>8 Q Why didn't you rebut this unsatisfactory</p> <p>9 rating?</p> <p>10 A I'm not sure. I think I spoke to</p> <p>11 Dr. Kremer about it in person, and I guess -- Yeah.</p> <p>12 I'm not sure why I didn't do one on this. I just</p> <p>13 recall the circumstances around it.</p> <p>14 Q So you agree that you missed something.</p> <p>15 You thought it was rated too harshly, this one?</p> <p>16 A Yes.</p> <p>17 Q If you turn to the next page in</p> <p>18 Exhibit 12 --</p> <p>19 A Yes.</p> <p>20 Q -- this appears to be an email from Renee</p> <p>21 Przygodzlek --</p> <p>22 A Yes.</p> <p>23 Q -- to Mike Kremer dated January 13, 2014</p> <p>24 reporting about her day with you; right?</p>
Page 282	Page 284
<p>1 Q So is this unsatisfactory rating fair and</p> <p>2 accurate?</p> <p>3 A No, because I had reviewed other things</p> <p>4 that were accurate; and CRNAs, anesthesiologists, and</p> <p>5 my cohorts alike miss multiple information, and it</p> <p>6 doesn't get ranked as harshly.</p> <p>7 From what I recall, like I said, I was</p> <p>8 with Kathleen and my cohort Kelly Gallagher had missed</p> <p>9 two crucial CV, cardiovascular histories; and she</p> <p>10 wasn't put on notice for that.</p> <p>11 Q Did you write a rebuttal to this</p> <p>12 evaluation?</p> <p>13 A I thought I did. I don't remember.</p> <p>14 Q Do you see it in Exhibit 11?</p> <p>15 A No. I don't think I did.</p> <p>16 Q Can you find Exhibit 3? It's the</p> <p>17 interrogatory responses?</p> <p>18 A Yes.</p> <p>19 Q If you turn to Page 27 --</p> <p>20 A Yes.</p> <p>21 Q -- on that page near the bottom there is a</p> <p>22 reference to a day on January 15 with Angela Keehn?</p> <p>23 A Yes.</p> <p>24 Q And I don't want to the talk about that</p>	<p>1 A Yes.</p> <p>2 Q In it she says that she worked, I worked</p> <p>3 with Maricel today. We had an okay day. Two spines,</p> <p>4 nothing unusual. Right?</p> <p>5 A Yes.</p> <p>6 Q So she is saying you did a good job?</p> <p>7 A Yes.</p> <p>8 Q She is saying that she did not leave me an</p> <p>9 evaluation, so I just wanted to follow-up with you;</p> <p>10 right?</p> <p>11 A Yes.</p> <p>12 Q Is that accurate, that you did not leave</p> <p>13 her an evaluation?</p> <p>14 A Yeah. I don't recall that I left with her</p> <p>15 one.</p> <p>16 Q Did you think that Kathleen Oskvarek, was</p> <p>17 her evaluation of you biased?</p> <p>18 A I think so.</p> <p>19 Q Why?</p> <p>20 A Because I thought this was just a little</p> <p>21 bit too harsh to have missed one item which was not</p> <p>22 actively relevant during the case, so I could have</p> <p>23 gotten a better rating if I had gotten most of it</p> <p>24 correct anyway and there is just this one item.</p>

<p style="text-align: right;">Page 285</p> <p>1 Q Why do you think that was biased against</p> <p>2 you based on -- Do you think it's biased against you</p> <p>3 based on your race or national origin or age?</p> <p>4 A I have a sense that she's had, she's heard</p> <p>5 of being on leave and just my whole event from before</p> <p>6 my leave.</p> <p>7 On a personal note, this is Vic</p> <p>8 Oskvarek's wife. Dr. Kremer had approached him</p> <p>9 before, and I had walked into their conversation of</p> <p>10 how I think that everybody is after me. And that</p> <p>11 evaluation that proceeded from Vic was mostly negative</p> <p>12 even though nothing really untoward happened in that</p> <p>13 case.</p> <p>14 Q Vic evaluated you before January 9th,</p> <p>15 2014?</p> <p>16 A I think I was with him at some point. I'm</p> <p>17 not sure if it was before this or afterwards.</p> <p>18 Q So you don't know?</p> <p>19 A No. I don't.</p> <p>20 Q So are you saying this evaluation on</p> <p>21 January 9th, 2014 was discriminating against you on</p> <p>22 the basis of race, national origin or age or not? I</p> <p>23 can't tell.</p> <p>24 A Well, there is some form of</p>	<p style="text-align: right;">Page 287</p> <p>1 treatments which should be known. She said she would</p> <p>2 "freak out" if a laryngospasm occurred. Needs a lot</p> <p>3 of direction and prompting.</p> <p>4 Q Did you agree with that evaluation?</p> <p>5 A No.</p> <p>6 Q Can you turn to Page 4 of Exhibit 11.</p> <p>7 That's this one.</p> <p>8 A Okay.</p> <p>9 Q On Page 4, does that have your explanation</p> <p>10 of what you dispute about Lea Forester's January 15,</p> <p>11 2014 evaluation?</p> <p>12 A Yes.</p> <p>13 Q So I think your reference there is to the</p> <p>14 Scopolamine patch?</p> <p>15 A Yes.</p> <p>16 Q That you suggested it, that they ended up</p> <p>17 doing something else but that it wasn't inappropriate</p> <p>18 for you to suggest it; is that right?</p> <p>19 A Yes.</p> <p>20 Q So did Lea have a different judgment about</p> <p>21 that than you?</p> <p>22 A Yes, because she still points out here</p> <p>23 that this is an outpatient procedure, and a</p> <p>24 Scopolamine patch wouldn't be appropriate for this</p>
<p style="text-align: right;">Page 286</p> <p>1 discrimination, but it's not distinct as to whether it</p> <p>2 pertains to my race or age.</p> <p>3 Q And that's because you think it was a</p> <p>4 minor error and it was evaluated too harshly?</p> <p>5 A Yes.</p> <p>6 Q The next evaluation is dated January 15</p> <p>7 from Lea Forester?</p> <p>8 A Yes.</p> <p>9 Q So this is an evaluation from Lea</p> <p>10 Forester; right?</p> <p>11 A Yes.</p> <p>12 Q From on the event on January 15, 2014?</p> <p>13 A Yes.</p> <p>14 Q And it rates you as unsatisfactory in</p> <p>15 several categories; right?</p> <p>16 A Yes.</p> <p>17 Q Can you read the comments out loud,</p> <p>18 please?</p> <p>19 A Very weak student. Unable to formulate an</p> <p>20 appropriate anesthetic plan of care. Example, wanted</p> <p>21 to put on a Scopolamine patch for an outpatient port</p> <p>22 placement with history of postop nausea and vomiting.</p> <p>23 Unable to describe treatment for venous air embolism</p> <p>24 and laryngospasm which are basic principles,</p>	<p style="text-align: right;">Page 288</p> <p>1 minor surgery. But this procedure was converted to</p> <p>2 general, so it was appropriate to have that as one of</p> <p>3 your regimen to avoid postop nausea and vomiting.</p> <p>4 So she didn't correct this part here</p> <p>5 that it was an outpatient. It was converted to</p> <p>6 general surgery because originally I think this is</p> <p>7 going be a MAC which is a monitored anesthesia or</p> <p>8 twilight where the patient is not going to be</p> <p>9 intubated, and the patient ended up being intubated;</p> <p>10 or we had planned to intubate the patient because</p> <p>11 prior to that there was a pediatric case of the same</p> <p>12 procedure, Portacath placement that went --</p> <p>13 It was a little bit complicated,</p> <p>14 converted from MAC to general because it took longer</p> <p>15 for the surgeon to place the port, and it was the same</p> <p>16 surgeon who was going to be doing this. That's why I</p> <p>17 figured, you know, it's a general. And this patient</p> <p>18 told me, I have severe postop nausea vomiting, and so</p> <p>19 my suggestion was within the standard of care.</p> <p>20 Q But others disagreed with you?</p> <p>21 A Others?</p> <p>22 Q Did Lea disagree with you about that?</p> <p>23 A She didn't show this to me. Yeah. She</p> <p>24 disagreed that Scopolamine is not appropriate.</p>

Page 289

1 Q The comment here about that you said you
2 would freak out if that happened, your rebuttal
3 indicates that you meant that as a joke?

4 A Yes. I was just making light of it.
5 I wasn't serious about what I said there.

6 Q Is it possible that Lea Forester didn't
7 recognize that as a joke and thought you meant it?

8 A I was snickering. Oh, I'd freak out.
9 Like I meant it in a joking way.

10 Q Okay. So you think she should have known
11 but you don't know if she knew you meant it as a joke;
12 right?

13 A Yeah. I presented it sort of making light
14 of it. Plus, I've had this experience before a couple
15 of times with one with a peds patient and another time
16 with an adult patient, and both times I acted
17 accordingly. I had no issues addressing with those
18 problems.

19 Q Did Lea know that?

20 A No. I told Dr. Kremer because we went
21 through this evaluation.

22 Q So when she heard you say you would freak
23 out, she didn't know about your prior experience with
24 that; right?

Page 290

1 A No.

2 Q You're agreeing with me, she didn't know?

3 A She didn't know.

4 Q On Page 4 of your rebuttal, next to her
5 name and date you write, Written on the same day, same
6 care day as Angela. And this evaluation appears to
7 have been written on January 21, 2014, right, from Lea
8 Forester?

9 A Yes. But I think what I meant there was I
10 was assigned with Angela another time, but I don't
11 recall that I gave her another eval that day. So I
12 don't know if that was what I meant with that.

13 Q Were you suggesting that Angela who is
14 Angela Keehn I believe and Lea were talking to each
15 other about how to evaluate you, or what do you mean
16 by saying it was written on the same day of care?

17 A I don't recall. I'm not sure it's
18 January 15. Oh, I wonder if because Angela Keehn's is
19 January 15th and Lea Forester is January 15th, I think
20 it might have been a reminder for us to revise this or
21 correct this because those are the same days but they
22 didn't really happen on the same days. So it might
23 just be a reminder for us.

24 Q So the next evaluation in Exhibit 12 is

Page 291

1 one from Angela Keehn dated January 15, 2014. Is that
2 the evaluation you're talking about?

3 A Yes, but I think I miswrote the date
4 because I think it was really the 17th that I was with
5 her.

6 Q Well, why do you say that?

7 A Because I can't be assigned to one CRNA or
8 two CRNAs in one day, so I'm thinking that I might
9 have dated this incorrectly because normally if you
10 are assigned to one CRNA in a day, you stay with that
11 CRNA.

12 Q Is that your handwriting at the top?

13 A Yes. At the bottom is Angela's.

14 Q I understand. Okay.

15 So this evaluation from Angela
16 contained several unsatisfactory ratings; right?

17 A Yes.

18 Q Can you read her comments at the bottom?

19 A Multiple problems with setup and prep.
20 Nitrous tank not open. And when asked if it was
21 checked, Maricel claimed she checked it. No page or
22 notification that she was seeing a teenage patient to
23 myself or Dr. Chagin (phonetic). Inaccurate area
24 assessment. Student did not see IV site or was too

Page 292

1 nervous to attempt which is okay because it was a
2 child. Adequate mask ventilation with assistance.
3 Successful intubation with assistance but was using
4 teeth as leverage. Needed constant prompting during
5 all aspects of the case, and there is more.

6 Lack of basic nursing skills, that is
7 ability to recognize EKG and heart rate on pulse ox.
8 Not correlating even when prompted to this issue.
9 Student had no idea that the pulse was 120. There was
10 a very clear tracing on the pulse ox and lots of
11 interference with the EKG.

12 Not able to count as a reliable
13 anesthesia team member when not able to recognize
14 simple monitoring readings. Not able to pick up on
15 changes in patient status.

16 Lack of knowledge of drug pharmacology.
17 No idea of duration of action for Rocuronium. Student
18 was checking twitches almost every three minutes.

19 Q If you stay on that second page there, did
20 you make a mistake relating to evaluating and
21 recognizing the pulse ox and the pulse rate?

22 A I didn't recognize that. I could also
23 check on the pulse ox as my secondary EKG or heart
24 rate source.

21 (Pages 289 to 292)

<p style="text-align: right;">Page 293</p> <p>1 Q So that was a mistake --</p> <p>2 A Yes.</p> <p>3 Q -- by you; right?</p> <p>4 A Yes.</p> <p>5 Q And is it true that you need to evaluate</p> <p>6 and watch both the EKG and the pulse ox for heart</p> <p>7 rate?</p> <p>8 A That wasn't what I was used to, and I</p> <p>9 realized later that that is the secondary monitor; but</p> <p>10 sometimes when there is interference like lighting, it</p> <p>11 could interfere with the readings of the pulse</p> <p>12 oximeter. Sometimes movements can also interfere with</p> <p>13 pulse ox accuracy.</p> <p>14 Q The next sentence says: Student had no</p> <p>15 idea that the pulse was 120. Is that true?</p> <p>16 A I think for that three-minute period from</p> <p>17 what I recall in the charting, I didn't catch that.</p> <p>18 Q So that's true and you didn't catch it;</p> <p>19 right?</p> <p>20 A Yes.</p> <p>21 Q In rebuttal in Exhibit 12 on Page 3, at</p> <p>22 the top it says: I concede I should have looked at</p> <p>23 the pulse ox in this case; right?</p> <p>24 A Yes.</p>	<p style="text-align: right;">Page 295</p> <p>1 Q And Angela Keehn believed that that was a</p> <p>2 lack of basic nursing skills; right?</p> <p>3 A That's her opinion.</p> <p>4 Q And as a result, she wrote here, Not able</p> <p>5 to count on you as a reliable anesthesia team member</p> <p>6 when not able to recognize simple monitor readings;</p> <p>7 right? That was her opinion?</p> <p>8 A Yes.</p> <p>9 Q Did Angela say or do anything in the</p> <p>10 course of this case during the case while it was going</p> <p>11 on that you thought was unprofessional or</p> <p>12 inappropriate?</p> <p>13 A Yes. When we were seeing the patient, she</p> <p>14 cut me off. During the preop, we had asked the</p> <p>15 patient, Where do you prefer your IV to be, and she</p> <p>16 said left. And when I looked at the left, I didn't</p> <p>17 see anything that stood out. And since I didn't want</p> <p>18 to subject the patient to additional IV insertions or</p> <p>19 pokes, I said, Is it okay if we looked at the right</p> <p>20 side? And she cut me off and said, No. If she wants</p> <p>21 the left, she gets the left. Let me look at it.</p> <p>22 So she just puts me aside or has me</p> <p>23 step aside. So she basically undermined me in front</p> <p>24 of the patient and the patient's parent who was there.</p>
<p style="text-align: right;">Page 294</p> <p>1 Q So that was a legitimate criticism of you?</p> <p>2 A Yes.</p> <p>3 Q And a significant criticism of you? Is</p> <p>4 this a significant issue, monitoring the pulse rate of</p> <p>5 the patient while under anesthesia?</p> <p>6 A Well, there is other parameters that we</p> <p>7 look at, not just one thing that will lead us to</p> <p>8 adjust our interventions or our actions. So we also</p> <p>9 had the blood pressure, the saturation. The EKG,</p> <p>10 although unreliable, we weren't going to be</p> <p>11 intervening with that heart rate because this</p> <p>12 particular procedure was an ablation. They're trying</p> <p>13 to trigger a fast heart rate to locate the abnormal</p> <p>14 sites of arrhythmias.</p> <p>15 So as much as one got missed, the other</p> <p>16 parameters I was monitoring closely to see if the</p> <p>17 patient's deteriorating or having problems.</p> <p>18 Q So what I asked was whether monitoring the</p> <p>19 heart rate was a significant component of providing</p> <p>20 safe anesthesia care?</p> <p>21 A Yes.</p> <p>22 Q And you didn't do that properly here;</p> <p>23 right?</p> <p>24 A Yes.</p>	<p style="text-align: right;">Page 296</p> <p>1 Q Did Angela then insert the IV on the left?</p> <p>2 A She did.</p> <p>3 Q So she found a good place?</p> <p>4 A She did.</p> <p>5 Q Was there anything else she did in the</p> <p>6 course of this case that you thought was inappropriate</p> <p>7 or unprofessional?</p> <p>8 A I don't recall if there was anything else.</p> <p>9 Q She talks in her write-up in the first</p> <p>10 page about checking the N-2 tank. What is that?</p> <p>11 A Nitrous tank, yes.</p> <p>12 Q And that it wasn't open and that she had</p> <p>13 asked if it was checked and you said that you had</p> <p>14 checked it?</p> <p>15 A Yes.</p> <p>16 Q Was it Angela's view that by checking it</p> <p>17 you should have opened it?</p> <p>18 MS. SIEGEL: I'm going to object. It calls for</p> <p>19 speculation.</p> <p>20 A Well, this is the IR suite. This is not</p> <p>21 like the OR suite where the Nitrous source is -- You</p> <p>22 can't control not opening it. It's just available</p> <p>23 right away fed into the anesthesia machine. So in the</p> <p>24 IR it's a separate tank.</p>

Page 297

1 Like I've worked in the IR before with
2 another CRNA; and they said, If you check it, you
3 don't necessarily have to keep it open. So once you
4 open it, it's ready for use.

5 But in an average four-hour case, we
6 don't use Nitrous on somebody who is high risk for
7 postop nausea vomiting because this is what we call a
8 pro-emetic agent. It induces vomiting. So I told her
9 I did check it, but I didn't think it was going to be
10 used for the case.

11 Plus, a CRNA I've worked with before in
12 the IR suite said, You could just turn the dial and
13 it's on. So it's not going to take like two seconds
14 to do that.

15 Q Did you do that?

16 A Do what?

17 Q Turn the dial and have it be on?

18 A We don't need to turn it on in that case.

19 Q You just said someone said you could just
20 check it, turn the dial and turn kit on?

21 A If we needed it.

22 Q What was the point of checking it if you
23 weren't going to open it or turn it on?

24 A Just to make sure there that there is no

Page 298

1 leak on the tank.

2 Q How would you check if there was a leak on
3 the tank?

4 A You open it; and if there is a hissing
5 noise coming from the valve or if you look at the
6 anesthesia machine and the Nitrous level is not, is
7 not at full, then you know that it's empty or it needs
8 to be replaced, that it's not ready to be used during
9 the procedure.

10 Q So did you turn it open and check it for a
11 leak?

12 A Yes.

13 Q Then you closed it?

14 A Yes.

15 Q And Angela thought you should have left it
16 open; right?

17 A Yes.

18 Q What did you base your understanding that
19 it didn't need to be open on?

20 A The patient has risks of -- I mean from
21 our studies, she has the hallmarks of risks for postop
22 nausea and vomiting. So she is young, female,
23 nonsmoker, this is her first surgery. So we reviewed
24 from lecture that we have to watch out for that to

Page 299

1 limit the instances of postop nausea and vomiting.

2 Q So it was your judgment that you didn't
3 need to have it open because you didn't think you'd
4 use it?

5 A Yes, and from my previous experience like
6 I said where another CRNA said you don't necessarily
7 have to have it open.

8 Q There is a reference here that you used
9 teeth as leverage when you were I think intubating the
10 patient?

11 A That's her perception.

12 Q So your hand touched or your wrist touched
13 this patient's teeth?

14 A I must have touched it with the side of my
15 palm, but not the blade. I think she is pointing, she
16 is alleging that I used the blade, I used the teeth as
17 a fulcrum for the blade to lift the jaw up and
18 visualize the airway; and I didn't do that. I must
19 have touched it with this (indicating) but not with
20 the blade.

21 Q So you did touch it with your wrist?

22 A I could have.

23 Q And is it possible to interpret that as
24 applying leverage to the teeth?

Page 300

1 A No, because the way she describes it,
2 leverage is basically using the teeth to help you lift
3 the jaw. So metal on teeth is a huge no-no for us
4 when intubating.

5 Q Are you allowed to use your wrist as
6 leverage on the teeth?

7 A No. I wasn't using it as leverage.

8 Q I just asked if you are allowed to.

9 A No. You are not.

10 Q There is a reference at the end to lack of
11 knowledge of drug pharmacology, no idea of the
12 duration of action for Rocuronium?

13 A Yes.

14 Q Student was checking for twitches almost
15 every 3 minutes. Was Rocuronium a drug that was on
16 that list that you needed to know by heart that we
17 talked about last time?

18 A Yes.

19 Q Did she ask you about the duration of
20 Rocuronium?

21 A Yes, So I said 40 minutes; and she said
22 that was wrong. It's 45 minutes. It's a range. It's
23 between 35 to 45 minutes. And every book has
24 different -- I mean every reference changes. It's not

Page 301

1 a fixed like just 40 minutes.

2 Q Couldn't it be that her point was that you
3 didn't need to be checking for twitches if Rocuronium
4 would last for longer?

5 MS. SIEGEL: Calls for speculation.

6 A No.

7 MR. LAND: Q That's impossible?

8 A It's not impossible. She asked me in
9 particular during the progression of the case what the
10 duration of action is of Rocuronium. And this
11 checking twitches every three minutes didn't happen.
12 I disputed that.

13 Q How often did you check twitches?

14 A I think at the beginning for the first
15 20 minutes I think I would maybe every 5 or 10.
16 I don't recall, but it's not every three minutes
17 because we're also adjusting gases, doing charting,
18 checking on the patient.

19 So it's really not possible to just be
20 doing this because this is a whole setup here to make
21 sure that your monitor is properly in contact with
22 your patient's pulses or the nerve sites, and you are
23 applying this nerve stimulation. So that takes some
24 time.

Page 302

1 And if I am doing documentation,
2 adjusting gases, giving medication, I can't be
3 checking twitches every three minutes. I think that's
4 an exaggeration.

5 Q So you were doing it every five minutes
6 you said?

7 A I don't recall. It might have been that,
8 or what's appropriate for --

9 Q So Rocuronium is a muscle relaxant; right?

10 A Yes.

11 Q So the idea of how long it lasts means
12 that you don't need to check the twitches while it's
13 in effect; right?

14 A That is the expected duration of action;
15 but depending on, you know, a patient's metabolism, it
16 could be burnt out sooner. Some people, you know,
17 metabolize it faster. Some metabolize it less.

18 But I don't know exactly at what point
19 she is saying I was checking these twitches every
20 three minutes because at the beginning everybody is
21 busy situating the patient. So by the time you get
22 back to the patient to check your twitches, there
23 might have been like ten or twenty minutes that had
24 passed.

Page 303

1 Q Isn't kind of her point here possibly that
2 you were checking for twitches when you didn't need to
3 because the Rocuronium would still be lasting and it's
4 not necessary and it was distracting you from looking
5 at other things like the pulse ox monitor?

6 MS. SIEGEL: Calls for speculation.

7 A No.

8 MR. LAND: Q That's not possible?

9 A That's not at the time that she asked me
10 the question. It was later on. From what I recall,
11 it was later on in the case when she asked for the
12 duration of action of Rocuronium.

13 Q Why was she asking you that?

14 A They ask us different questions about
15 drugs that we're giving and, you know, specifics about
16 the case just to quiz us.

17 Q What point of the case was it? You said
18 it was later. Later than what?

19 A Like I think it was a three-hour case; so
20 it was later from when we first like intubate where,
21 you know, the paralytic would have been freshly given
22 them. So I'm not sure that this is correlated. My
23 recollection is she just asked me, quizzed me in
24 particular on the duration of Rocuronium.

Page 304

1 Q For no reason she just quizzed you? Is
2 that what you're saying?

3 MS. SIEGEL: Objection. You're asking for
4 speculation.

5 A Well, they ask me questions frequently.

6 MR. LAND: Q Was there anything about the
7 timing of when she asked about the Rocuronium,
8 duration of action that led you to understand why she
9 was asking you?

10 A No. She didn't indicate, Do you know the
11 duration of action. She didn't correlate those two
12 different situations.

13 Q But the note she writes here does, right,
14 doesn't know the duration and was checking for
15 twitches every three minutes?

16 A Yes; but she also says, No idea of
17 duration of action when, in fact, I told her. I gave
18 her an answer. I said 40 minutes; and she countered
19 no, it's 45 minutes.

20 Q Let's turn to the next evaluation in
21 Exhibit 12. I think this is the January 20, 2014
22 evaluation from Jill Wimberly.

23 A January.

24 Q I'm sorry. This is a January 17, 2014

24 (Pages 301 to 304)

Page 305	Page 307
<p>1 evaluation from Jim Miller?</p> <p>2 A Yes.</p> <p>3 Q This one is positive; right?</p> <p>4 A Yes.</p> <p>5 Q Is this fair and accurate?</p> <p>6 A Yeah.</p> <p>7 Q So, Maricel, do you find the evaluations</p> <p>8 that were positive of you always fair and accurate?</p> <p>9 A For the most part.</p> <p>10 Q Could you turn to the next one from Jill</p> <p>11 Wimberly, January 20, 2014. So do you remember this</p> <p>12 day?</p> <p>13 A Some parts, yes.</p> <p>14 Q This is the third evaluation seen of you</p> <p>15 from Jill Wimberly?</p> <p>16 A Yes.</p> <p>17 Q Do you remember there was May 10, 2013 and</p> <p>18 then June 20, 2013 and this one.</p> <p>19 I have a general question for you.</p> <p>20 Other than those three times where you worked with</p> <p>21 Jill Wimberly, did you ever interact with her at all?</p> <p>22 A There was that time where she took over</p> <p>23 for Lea's case; but then I hadn't had lunch, so I was</p> <p>24 sent to for lunch by Lea. And then Ray said you could</p>	<p>1 A Yes.</p> <p>2 Q -- you've indicated that in some of your</p> <p>3 writings that she said to you something like, Go, go,</p> <p>4 go, go before you performed a procedure; right? Other</p> <p>5 than that -- and I'll talk more about that -- are you</p> <p>6 alleging that Jill said or did anything unprofessional</p> <p>7 in this case on January 20?</p> <p>8 A Yes. Like she was constantly badgering me</p> <p>9 with questions; and at the start of the case, it's</p> <p>10 like, What next, what are you going to do next.</p> <p>11 Before I can even move in one direction, she would be</p> <p>12 on my face.</p> <p>13 And then when I tried to -- She was</p> <p>14 trying to set up the patient, and I had the IV bag.</p> <p>15 So for me to be able to start with getting my</p> <p>16 introduction drugs ready, I had crossed or I had put</p> <p>17 the IV bag on one side which was crossing the patient,</p> <p>18 and she immediately snapped at me for that and started</p> <p>19 writing disorganized because of that without asking me</p> <p>20 the reason why I did that.</p> <p>21 And then just the constant questioning</p> <p>22 and misrepresenting my answers. Like at one point she</p> <p>23 asked me how many twitches at this point should you</p> <p>24 have back. It was I think ten minutes by then since</p>
Page 306	Page 308
<p>1 just go home after that. So I had that brief</p> <p>2 interaction with her, so I ended up not being under</p> <p>3 her.</p> <p>4 And then, yeah, of course like off and</p> <p>5 on in the hallway, you know, I would see her or like</p> <p>6 in the monitor room like the seven tower where she was</p> <p>7 talking to Eva.</p> <p>8 Q So how often would you see her when it</p> <p>9 wasn't for a case?</p> <p>10 A Well, there is also grand rounds when we</p> <p>11 attend that, probably maybe three times a month.</p> <p>12 I mean in the hallway if we're on the same floor, then</p> <p>13 I'd see her in passing.</p> <p>14 Q Did you ever have any kind of meaningful</p> <p>15 conversation with her, meaningful meaning longer than</p> <p>16 just hello or anything like that outside of the cases</p> <p>17 that you were involved with her?</p> <p>18 A Not that I recall.</p> <p>19 Q So the only times you ever interacted with</p> <p>20 her in a way that involved communication between the</p> <p>21 two of you were the three times you were evaluated?</p> <p>22 A I think so, yes. That's right.</p> <p>23 Q During the January 20, 2014 evaluation or</p> <p>24 during that case --</p>	<p>1 we gave the paralytic, and I said zero. And she said,</p> <p>2 What did you say, four? I heard you say four. So she</p> <p>3 kept insisting that I was lying.</p> <p>4 And then she also suggested that I</p> <p>5 should have ordered blood which she should have</p> <p>6 specified that the night before when I presented the</p> <p>7 case to her. And I had checked with the other</p> <p>8 surgeons, the surgeons and the residents if that would</p> <p>9 be necessary, and they said no. And the patients been</p> <p>10 typed and screened. We could definitely do a flash</p> <p>11 type and cross if need be.</p> <p>12 But she was irate about that, that I</p> <p>13 didn't hold blood even though surgery says there is no</p> <p>14 need and she didn't specify it. Plus, with the</p> <p>15 shortage of blood, we don't just randomly order it if</p> <p>16 we don't see that it's a necessity.</p> <p>17 Then she was teaching me things which</p> <p>18 didn't make sense in terms of the ventilator, and I</p> <p>19 couldn't really argue with her against that. I just</p> <p>20 like let her, you know, talk to me because the more I</p> <p>21 argued -- And this is what Karen advised me too -- the</p> <p>22 more I argued, the more she will get irritated and</p> <p>23 just be verbally hostile to me.</p> <p>24 Q Did she raise her voice to you?</p>

Page 309

Page 311

1 A Yes.
 2 Q How often?
 3 A Multiple times. When I'm trying to get to
 4 my setup, it was, What are you going to do next, what
 5 are you going to do next. So she was constantly
 6 barking at me.
 7 Q You are saying she raised her voice
 8 whenever she would say what are you going to do next?
 9 That's what I was asking. When did she raise her
 10 voice?
 11 A Yes, when she would ask me questions.
 12 Q What do you mean by she would raise her
 13 voice. How loud was it?
 14 A Well, it was right on my face, and of
 15 course it was loud enough that I was -- I think the
 16 point is to startle me and to get me I guess
 17 discombobulated.
 18 Q Do you think that's what she was trying
 19 to?
 20 A That's her gesture that I perceived. She
 21 was just here (indicating).
 22 Q What do you mean by right on your face?
 23 A Her face is right on me.
 24 Q You are putting your hand like 3 inches

1 A No. I've had other anterior approaches
 2 for spinal fusion, and we're not required to order
 3 blood prior.
 4 Q That's not really what I asked.
 5 A No.
 6 Q I didn't ask if it was required. I asked
 7 was it common to have blood on hand for this type of
 8 surgery?
 9 A Not to my experience.
 10 Q Did you look up in books --
 11 A Yes.
 12 Q -- in preparing for this whether that was
 13 required or not or whether this was suggested?
 14 A I reviewed that in Anesthesia For Surgical
 15 Procedures.
 16 Q Who writes that book; do you remember?
 17 Was it Jaffe?
 18 A No.
 19 Q Miller and McCann?
 20 A I think it was Miller and McCann.
 21 Q So you are saying in the Miller and McCann
 22 textbook for this type of surgery it doesn't indicate
 23 you need blood on hold?
 24 A It's a possibility or something that's

Page 310

Page 312

1 from your face?
 2 A Yes. That's how close she was. What are
 3 you going to do next, what are you going to do next?
 4 It was very daunting.
 5 Q She got within 2 or 3 inches of your face?
 6 A Yes.
 7 Q All of the time?
 8 A During the beginning of the case as we
 9 were trying to get organized.
 10 Q Did other people in the room notice this?
 11 A They were busy getting set up on that
 12 side.
 13 Q So they didn't notice it?
 14 A I don't know. I was looking at her. I
 15 was trying to answer her in the best way I can.
 16 Q Talk about having blood on hold, was it
 17 the nature of this surgery that would be require blood
 18 being on hold?
 19 A It's a potential if they transgress a
 20 blood vessel along the way.
 21 Q Wasn't this surgery the type of surgery
 22 that often requires blood?
 23 A No.
 24 Q No?

1 suggested; but it's not, you know, in the like list of
 2 priorities I guess.
 3 Q But Jill told you she thought it was
 4 during the case?
 5 A She did.
 6 Q And you are saying she should have told
 7 you the night before?
 8 A Yes. We discussed these plans for the
 9 next day when I presented her with the cases, the
 10 patient's history or medical history. That's one of
 11 the things that's crucial to be told to us, an SRNA to
 12 order the next day if they thought it was that
 13 important.
 14 Q Their evaluation writes that you didn't
 15 know the anatomy of the spinal cord or spinal cord
 16 vessels that could be injured and abdominal vessels
 17 that could be injured?
 18 A She asked me what are the blood vessels
 19 that could be affected in that approach of spinal
 20 fusion surgery, and I gave her I think three or four
 21 blood vessels. And then she asked what else, what
 22 else?
 23 I just named a few from, you know, my
 24 reference; and she wanted to know more in detail of

26 (Pages 309 to 312)

Page 313

1 the whole, you know, whatever, blood circulatory
2 network is in that area. So I gave her at least four
3 blood vessels that I could recall, and she wasn't
4 satisfied with that.

5 Q Do you know what she means by saying you
6 didn't know appropriate action for change in patient's
7 status with reduced heart rate, reduced blood
8 pressure, and doesn't know what to do, says I'm not
9 sure?

10 A Where is that at? No. I don't know what
11 she referred to then. I know that we had a discussion
12 about calcium channel blocker which is below the heart
13 rate and a blood pressure medication, but she wanted
14 me to explain the whole mechanism of action which her
15 explanation didn't really make sense; and I had asked
16 Hakeem, have you had that encounter with her where she
17 just fires off some random information. And Hakeem
18 testified or mentioned to me that sometimes I don't
19 understand what she is saying.

20 Q Did you have communication with her about
21 the dosage of glycol?

22 A Glycopyrrolate?

23 Q Yeah.

24 A Yes. She had asked what dose of

Page 314

1 glycopyrrolate do we use; and my answer is, This is
2 the ratio of what we use in terms of when we mix it
3 with neostigmine because those are your reversal
4 agents.

5 Q And she wanted to know what the dosage
6 would be if used it by itself?

7 A Yes.

8 Q But you didn't know; is that right?

9 A I just know of its use in that particular
10 situation when it's mixed with neostigmine because I
11 told her the dose.

12 Q For that mix?

13 A For that mix.

14 Q That's not what I'm asking you about. I'm
15 asking if you knew the dose for --

16 A Just by itself.

17 Q The reference is glycol. I can't remember
18 the --

19 A Glycopyrrolate.

20 Q She asked you that, and you didn't know;
21 right?

22 A No.

23 Q You didn't?

24 A I didn't know what she was really getting

Page 315

1 to because we don't use glycol by itself in the
2 surgery.

3 Q You don't?

4 A No. Glycopyrrolate, it's to control
5 saliva. It's a drying agent for adults. For
6 pediatrics, you use it as a heart rate control
7 medication. I mean we have used glycopyrrolate for
8 our palliative and hospice patients to control their
9 secretions. But if you're using it in a surgery like
10 this, you use it with neostigmine.

11 Q You're saying you would never use it on
12 its own in this surgery?

13 A No, no, because why are we going to dry a
14 patient's secretions. The patient's sedated. They're
15 on their back, and we suction the mouth. But if you
16 use glycopyrrolate, it's to dry their secretions.

17 But we use that with neostigmine
18 because neostigmine can cause you to have a lot of
19 secretions. That's the neutralizing agent for
20 neostigmine. That's why I answered her that way which
21 is appropriate for this particular case.

22 So if she is veering off towards
23 glycopyrrolate's other uses which is for pediatrics to
24 raise their heart rate and for palliative patients to

Page 316

1 dry their secretions, that's not appropriate in this
2 setting.

3 Q What you wrote in your rebuttal was that
4 most CRNAs do not know this form of dosage without
5 referring to a handbook. You wrote that on Page 6.

6 A Yes, because I've asked, and it usually
7 goes hand in hand.

8 Q Did you not know at that time what its
9 dosage would be to use it alone?

10 A No.

11 Q You didn't know it; right?

12 A No.

13 Q You are agreeing with me?

14 A I didn't know that.

15 Q That's just the way I was asking the
16 question. Sorry.

17 A Okay.

18 Q You indicate in your rebuttal on Page 7
19 that I pulled out a paper showing that in addition to
20 knowing the numbers from memory, they were reported on
21 a guideline commonly used by anesthesiology residents
22 at Rush. Did you pull that out in the OR?

23 A No, not at that time; but I looked it up
24 later.

27 (Pages 313 to 316)

Page 317

1 Q Does that mean when you say I pulled out,
2 for yourself?
3 A Yes, just to verify her --
4 Q Afterwards you pulled it out?
5 A I believe it was afterwards.
6 Q Like did you show it to her?
7 A No.
8 Q Did you make a mistake during this
9 proceeding, this case?
10 A Like when I was extubating because she
11 startled me by saying. Go, go, go; and I had
12 extubated without deflating the balloon which I had
13 never done before.
14 Q That was a mistake; right?
15 A Yes.
16 Q Was that a significant mistake?
17 A It could be.
18 Q So the ET tube involves the balloon that's
19 in the throat?
20 A Yes.
21 Q And it needs to be deflated before it's
22 pulled out?
23 A Yes.
24 Q And you pulled it out without deflating

Page 318

1 it; right?
2 A When she startled me, yes.
3 Q I'm just asking you if you did that.
4 A Yes.
5 Q And you're saying she came up behind you
6 and yelled go, go, go, go?
7 A She was near enough in my ear to say like,
8 to startle me to say go, go, go.
9 Q I don't understand the context. Explain
10 the context.
11 A I think she was right here, and I was
12 about to deflate, but she says go, go, go, go on my
13 ear; and so inadvertently I extubated the patient.
14 Q Was she trying to hand you a syringe?
15 A No. The syringe is right here next to me.
16 Q You use a syringe to deflate it; right?
17 A Yes.
18 Q The balloon?
19 A Yes.
20 Q Did you have it in your hand, the syringe?
21 A I think it might have been attached to it.
22 I might have it had it in my hand, or it might have
23 been attached to the pilot which is like the little
24 pigtail that's attached to the balloon. I don't

Page 319

1 recall exactly.
2 Q If you had it right there, why didn't you
3 use the syringe?
4 A Being startled after, you know, with the
5 way she screamed at me, I guess I acted, you know,
6 hastily from being startled by her.
7 Q In her evaluation she says, Removed ET
8 without attempting to deflate cuff, checking tape even
9 after being told two times to do so.
10 A No, no. There was not enough time for her
11 to instruct me to do this. From my recollection, I
12 was in the process of extubating when she screamed at
13 me go, go, go.
14 Q Was there any hurry at that time?
15 A No. I don't know why she had to do that.
16 Q But why did you pull it out so quickly?
17 MS. SIEGEL: It's been asked and answered
18 multiple times.
19 A Because she startled me.
20 MR. LAND: Q Was there a technical reason that
21 you needed to proceed more quickly in your action?
22 That's what I'm wondering.
23 A No. Being startled I think caused me to
24 act that quickly.

Page 320

1 Q We talked before in 2013 about you thought
2 Jill Wimberly was trying to convince other CRNAs to
3 rate you poorly; right?
4 A Yes.
5 Q Do you think she did that in 2014?
6 A It's possible. She was still hanging out
7 with Eva then.
8 Q But do you think that that's what
9 happened?
10 A I don't have any -- No. I don't have any
11 idea.
12 Q Let's turn to the next page of this
13 exhibit. This is an email from Eva Fisher to Mike
14 Kremer --
15 A Yes.
16 Q -- dated January 22nd.
17 MS. SIEGEL: What are you looking at?
18 A Rush 98.
19 MR. LAND: In Exhibit 12.
20 Q This is an email from Eva Fisher to Mike
21 Kremer dated January 22nd, 2014 about you?
22 A Yes.
23 Q And this is an email saying she did not
24 witness but it was reported to her by a student who

28 (Pages 317 to 320)

Page 321

Page 323

1 stepped in and intervened that Maricel was attempting
 2 to place an IV and ETT today, and her first attempt
 3 was unsuccessful. She left the Angiocath sheath in
 4 the skin. She removed the needle part of the
 5 Angiocath and was preparing to re-insert the same
 6 Angiocath without a sheath. The senior stepped in and
 7 told her she did not have a sheath and brought her a
 8 new Angiocath. Did that happen?
 9 A Not the way she reported it here.
 10 Q Did you try to insert the needle part of
 11 the Angiocath without a sheath?
 12 A Not knowingly.
 13 Q Okay. Did you try to do that? Did that
 14 actually happen?
 15 A Can I explain to you what happened
 16 exactly?
 17 Q I just want to know if you did that, and
 18 you said not knowingly. I want to know if it
 19 happened.
 20 A It happened.
 21 Q Was there a senior student there who
 22 stopped you?
 23 A No. She didn't stop me. She pointed out
 24 that, you know, sheath fell off; and I didn't realize

Page 322

1 it. So I just had the needle part of it, not knowing
 2 that the sheath had slipped out, and this happened to
 3 my other classmate too, Shanti (phonetic). This is a
 4 defective product.
 5 Q That is what happened here.
 6 A Yes.
 7 Q So you had the needle without the sheath.
 8 You were trying to insert it, and the student said
 9 something to you and then you stopped?
 10 A No.
 11 Q Did you actually insert it?
 12 A I inserted the needle thinking that the
 13 catheter was still in there because I didn't see that
 14 the sheath fell out; and then that senior, actually
 15 she was my classmate saw it, and she pointed out,
 16 well, your sheath fell off.
 17 And I asked her, Do you want to try
 18 because normally if we missed one, you don't want to
 19 keep trying; or sometimes some students do a second
 20 attempt. But, you know, we are told just one attempt
 21 and then have somebody try again.
 22 Q So is it true that you made one attempt,
 23 it didn't work, and you tried it again?
 24 A No. I just made one attempt.

1 Q Do you know who that student was?
 2 A Kelly Gallagher.
 3 Q The next evaluation in Exhibit 12 looks
 4 like it's dated January 24, 2014 from Renee
 5 Przygodzlek?
 6 A Yes.
 7 Q And it appears to be a favorable or
 8 satisfactory evaluation; is that right?
 9 A Yes.
 10 Q Was this fair and accurate?
 11 A I can't recall the details of it, but I
 12 didn't really sign it. She didn't discuss it with me,
 13 how she arrived at her ratings for me.
 14 Q I'm sorry. What?
 15 A I don't know that it's entirely fair that
 16 I just had the lower satisfactory rating on a majority
 17 of them. I just don't really remember the details
 18 that well.
 19 Q Okay. So she wrote: Still needs
 20 continuous support; right?
 21 A Yes.
 22 Q Did you agree with that?
 23 A At that time I think I did.
 24 Q In your rebuttal on Page 9, don't you

Page 324

1 write, I have no rebuttal here. I did a bad job that
 2 day. I suspect that Renee is someone who tries to be
 3 fair. Is that accurate that you wrote that?
 4 A Yeah. I wrote that.
 5 Q Is that still accurate?
 6 A Yeah.
 7 Q So this is an example of an evaluation
 8 that's fair and accurate and critical; right?
 9 A Yes.
 10 Q And that you did a bad job that day?
 11 A Not my best I guess.
 12 Q I'm reading your words. I did a bad job
 13 that day. Is that accurate?
 14 A Yes.
 15 Q The next thing in your rebuttal is: This
 16 evaluation occurred the day following the episode with
 17 Jill Wimberly. Is that accurate?
 18 A The next thing in your rebuttal is this
 19 evaluation. It's shortly after. This is the 20th.
 20 So, no, that's not accurate.
 21 Q Right. It's four days later; right?
 22 A Yes.
 23 Q And in your rebuttal you are explaining
 24 that, I don't know, you were feeling the after effects

29 (Pages 321 to 324)

Page 325

1 emotionally of dealing with Jill Wimberly and that's
2 why you performed poorly on January 24th; is that
3 right?

4 A Yes.

5 Q Do you think that people could view that
6 as excuse, that four days later you are saying you
7 couldn't emotionally handle being in the case?

8 A Well, having gone through like a difficult
9 period with her, I definitely can be reminded in
10 intense situations. But I didn't know how to gauge
11 her evaluation of me, so I had this apprehension that
12 maybe I'll get another unsatisfactory which made me
13 really stressed out.

14 Q Was Rush allowed to evaluate you based on
15 what you actually did on the 24th of January?

16 A Yes.

17 Q And it's not right what you wrote here
18 that it was the day following the episode with Jill;
19 right?

20 A Yes. I made a mistake there.

21 Q Was that a mistake that was attempting to
22 support your argument, that the reason you had
23 problems was because of your emotional state?

24 A I'm sorry. What is the question?

Page 326

1 Q Were you trying to be more persuasive
2 about why your emotional state was bad that day by
3 misrepresenting the sequence of days?

4 A No. I still felt that I was stressed out,
5 like just feeling that I'm getting scrutinized
6 constantly. So there is always that sense of like
7 doom and gloom because Dr. Kremer reminds me that just
8 one unsatisfactory and you might be out.

9 Q Is that what happened to you, one
10 unsatisfactory and you were out?

11 A No, no.

12 Q There were lots of unsatisfactory ratings
13 before you were dismissed; right?

14 A Yes.

15 Q The next evaluation --

16 MS. SIEGEL: Before you go on, we're just about
17 at 4:30 here. Why don't we stop for the day.

18 MR. LAND: Why don't we do the next one before
19 we stop.

20 MS. SIEGEL: Okay.

21 MR. LAND: Q The next evaluation in Exhibit 12
22 is February 3rd, 2014?

23 A Yes.

24 Q From Jillian Klunk?

Page 327

1 A Yes.

2 Q And she rated you with unsatisfactory
3 ratings in a couple different categories; right?

4 A Yes.

5 Q Can you read what she wrote there?

6 A Make sure you stop. Take time to think
7 about what you are doing and why. Pay attention to
8 what others are doing around you. Reversal should
9 always be given when DMR is dosed during the case.
10 Make sure the information you are giving to M.D. is
11 correct. Your effort can be commended, but my trust
12 in you is not progressing. I feel as though I need to
13 still watch you do everything. Slow down and take the
14 time to complete tasks correctly, appropriately. Will
15 have, CRNAs MDs will have more trust in you.

16 Q Was this a fair and accurate evaluation of
17 you on that day?

18 A I don't think so.

19 Q Can you look at Page 9 of your rebuttal?

20 A Yes.

21 Q The reference to Jillian Klunk on
22 February 3, 2014?

23 A Yes.

24 Q The first sentence says: This evaluation

Page 328

1 is included here for completeness. In fact, I believe
2 that Miss Klunk's criticism was legitimate. Is that
3 what you wrote?

4 A Yes.

5 Q Is that true?

6 A Well, in terms of that one mistake.

7 Q Is what you wrote true is what I'm asking
8 you?

9 A Yes.

10 Q You believe her criticism of you was
11 legitimate?

12 A Yes.

13 Q The next paragraph down says: Still this
14 was not a good day for me. Is that true?

15 A I guess, but I don't recall now. I guess
16 it is.

17 Q Well, you wrote that; right?

18 A Yes.

19 Q Are you backing away from what you wrote?

20 A No.

21 Q Okay. You indicate there that you've been
22 gone for one week for your husband's grandmother's
23 death and funeral and that it was your first day back
24 from that?

<p style="text-align: right;">Page 329</p> <p>1 A Yes.</p> <p>2 Q I'm sorry that you had that experience.</p> <p>3 My question is: Is Rush allowed to</p> <p>4 evaluate your performance in clinicals irregardless of</p> <p>5 whether you had some outside issue addressing your</p> <p>6 emotional state?</p> <p>7 A Yes.</p> <p>8 Q You see the last entry there under your</p> <p>9 rebuttal says Miss Klunk comments, and I do not</p> <p>10 dispute that I need a prompting and seemed unsure?</p> <p>11 A Yes.</p> <p>12 Q Is that accurate?</p> <p>13 A I guess to some extent.</p> <p>14 Q I'm asking if your writing is accurate,</p> <p>15 what you said?</p> <p>16 A Yes.</p> <p>17 Q The paragraph above that has to do with</p> <p>18 interaction between you and the attending about drug</p> <p>19 dosing during the case?</p> <p>20 A Yes.</p> <p>21 Q It ends with: I admit that this was a</p> <p>22 misunderstanding on my part; is that right?</p> <p>23 A Yes.</p> <p>24 Q Is there anything about this evaluation</p>	<p style="text-align: right;">Page 331</p> <p>1 MR. LAND: I think we can stop there.</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11 (Whereupon the deposition of</p> <p>12 Ms. Marcial was adjourned and</p> <p>13 scheduled to reconvene sine die.)</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>
<p style="text-align: right;">Page 330</p> <p>1 you thought was discriminatory against you in any way?</p> <p>2 A I thought this was harshly graded in terms</p> <p>3 of if I missed one IV and I just get a failing mark</p> <p>4 and also this misunderstanding which it didn't</p> <p>5 affect -- I was able to be correct that or to address</p> <p>6 the mistake, but I still was rated failing on it.</p> <p>7 Q So you are saying -- I just want to make</p> <p>8 sure I understand. I asked you if this evaluation</p> <p>9 which you say you don't dispute is discriminatory, and</p> <p>10 I think you said yes.</p> <p>11 A I pointed out my reasoning that this</p> <p>12 grading seems very harsh, and so I don't agree that</p> <p>13 it's that fair.</p> <p>14 Q Maricel, how can you say you think your</p> <p>15 criticism is legitimate and then say that it's</p> <p>16 discriminatory and unfair?</p> <p>17 A I guess at this point, yes. I have to</p> <p>18 have admit that I made a mistake; and her pointing</p> <p>19 that out not necessarily means it's discriminatory,</p> <p>20 but it's just the severity to which I was rated feels</p> <p>21 discriminatory.</p> <p>22 Q Why?</p> <p>23 A Because I corrected the mistake, and she</p> <p>24 didn't think that that was enough.</p>	<p style="text-align: right;">Page 332</p> <p>1 UNITED STATES DISTRICT COURT)</p> <p>2 NORTHERN DISTRICT OF ILLINOIS) SS.</p> <p>3 EASTERN DIVISION)</p> <p>4</p> <p>5 I have read the foregoing transcript of my</p> <p>6 deposition, taken on March 6, 2018, consisting of</p> <p>7 Pages 214 through 329, inclusive, and I find it is a</p> <p>8 true and correct transcript of my deposition so given</p> <p>9 as aforesaid.</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15 MARICEL MARCIAL</p> <p>16</p> <p>17 SUBSCRIBED AND SWORN TO</p> <p>18 before me this _____ day</p> <p>19 of _____, 2018.</p> <p>20</p> <p>21 Notary Public</p> <p>22</p> <p>23</p> <p>24</p>

1 STATE OF ILLINOIS)
) SS.
2 COUNTY OF COOK)

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4
5 I, Erin McLaughlin, CSR, do hereby certify
6 that I am a court reporter doing business in the City
7 of Chicago, that I reported in shorthand the testimony
8 given at the deposition of MARICEL MARCIAL, on
9 March 6, 2018, and that the foregoing is a true and
10 correct transcript of my shorthand notes so taken as
11 aforesaid.
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17 Certified Shorthand Reporter
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A				
abdominal 312:16 abilities 269:6 ability 215:8 249:21 292:7 ablation 294:12 able 219:20 220:10 220:13 221:15 222:13 234:18 292:12,13,14 295:4,6 307:15 330:5 abnormal 280:21 280:23 281:2,22 294:13 absence 238:5,7,11 240:14 256:22 258:10 260:22 261:2,14 262:6 academic 252:9 266:21 accountability 255:17 accuracy 293:13 accurate 282:2,4 284:12 305:5,8 323:10 324:3,5,8 324:13,17,20 327:16 329:12,14 accused 245:15 achievement 250:24 act 234:19 319:24 acted 289:16 319:5 action 249:14 250:4 292:17 300:12 301:10 302:14 303:12 304:8,11 304:17 313:6,14 319:21 actions 294:8 actively 224:21 259:3 284:22 actual 281:13 acuity 233:5 add 255:8 added 226:12	277:21 addition 316:19 additional 295:18 address 330:5 addressing 289:17 329:5 Adequate 292:2 adequately 251:4 adjourned 331:12 adjust 294:8 adjusting 301:17 302:2 admit 329:21 330:18 adult 289:16 adults 315:5 advance 216:15 advised 216:11 308:21 advocates 255:15 affect 330:5 aforsaid 332:9 333:11 afternoon 215:2 age 241:22 242:10 243:1 244:1 246:5 246:7 247:15,24 248:4 285:3,22 286:2 agent 297:8 315:5 315:19 agents 314:4 agree 230:4 250:11 255:11,19 283:14 287:4 323:22 330:12 agreeing 290:2 316:13 air 286:23 airway 299:18 alike 282:5 alleging 299:16 307:6 allowed 262:7,10 263:23 264:5 265:12 266:24 267:22 268:1,4,17 268:22 300:5,8	325:14 329:3 alluded 260:5 altogether 239:18 anatomy 312:15 anesthesia 216:9,10 217:6 220:14 221:16,18,20 222:7 233:17 249:22 251:12 275:24 288:7 292:13 294:5,20 295:5 296:23 298:6 311:14 anesthesiologists 233:1 282:4 anesthesiology 316:21 anesthetic 286:20 Angela 273:19 282:22 290:6,10 290:13,14,18 291:1,15 295:1,9 296:1 298:15 Angela's 291:13 296:16 Angiocath 321:3,5 321:6,8,11 answer 225:11 266:18 304:18 310:15 314:1 answered 244:24 276:5 315:20 319:17 answers 307:22 anterior 311:1 anymore 218:16 221:4 223:5 250:22 anyway 284:24 appeals 223:7 APPEARANCES 213:1 appeared 213:6,12 appears 240:5,7 283:20 290:6 323:7 apply 215:5 233:17 applying 299:24	301:23 appraisal 273:24 apprehension 325:11 approach 312:19 approached 285:8 approaches 311:1 appropriate 286:20 287:24 288:2,24 302:8 313:6 315:21 316:1 appropriately 327:14 area 226:16 251:5 275:3 291:23 313:2 areas 252:16 argue 308:19 argued 236:24 308:21,22 argument 325:22 arrest 234:14 arrhythmias 294:14 arrived 228:14 323:13 Ashley 262:18 aside 229:13 295:22,23 asked 223:13 235:8 241:14 243:10,10 244:2,12 245:1 247:3 253:5,16 267:9 274:19 291:20 294:18 295:14 296:13 300:8 301:8 303:9 303:11,23 304:7 307:23 311:4,6 312:18,21 313:15 313:24 314:20 316:6 319:17 322:17 330:8 asking 225:11 235:6 244:5 267:19 270:2 272:6 276:8 303:13 304:3,9	307:19 309:9 314:14,15 316:15 318:3 328:7 329:14 aspects 292:5 assessment 237:9 280:14 281:18,23 291:24 assessments 224:1 assigned 250:24 265:2,12 266:17 266:21 267:5 270:16,21 271:7 271:13 273:19 274:12,16 276:9 276:13,19 290:10 291:7,10 assignments 217:1 275:20,23 assistance 292:2,3 ASSOCIATES 213:3 assumed 246:15 assumes 246:20 attached 318:21,23 318:24 attain 251:14 252:19 attempt 292:1 321:2 322:20,20 322:22,24 attempting 319:8 321:1 325:21 attend 306:11 attending 329:18 attendings 237:1 attention 264:17 327:7 AV 281:9 available 279:16 296:22 average 297:5 avoid 270:5 276:6,7 276:21,24 288:3 aware 256:13 a.m 212:20
				B

back 215:2 223:11 223:14 227:10 230:11 232:19 237:18,19,24 238:12 240:9,18 250:20 253:1,23 254:6 267:11 272:12 275:14 276:5,16,22 302:22 307:24 315:15 328:23	328:1,10 believed 295:1 bench 221:13 benefit 273:22 best 247:5 248:1 310:15 324:11 better 225:12 227:24 284:23 bias 255:22,24,24 biased 256:7 271:14 284:17 285:1,2 bit 284:21 288:13 BLACKWELL 213:8 blade 299:15,16,17 299:20 blink 257:21 block 281:9 blocker 313:12 blood 294:9 308:5 308:13,15 310:16 310:17,20,22 311:3,7,23 312:18 312:21 313:1,3,7 313:13 Bloomer 266:23 blow 247:16 Bldv 213:3 bolded 228:9,23 book 217:4 221:20 300:23 311:16 books 311:10 bottom 229:15 237:17 273:8 278:1 280:24 281:8 282:21 291:13,18 break 263:19,21 breaks 260:8 brief 227:6 277:6 306:1 bring 219:19 brought 221:13 321:7 bullet 278:4,12 burnt 302:16 business 333:6	busy 302:21 310:11 C calcium 313:12 call 297:7 called 212:13 215:14 216:17 calling 231:15 calls 235:2 242:19 242:21 268:11 296:18 301:5 303:6 capability 236:19 capacity 212:7,8,9 capture 221:19 cardiovascular 257:18 282:9 care 216:9,17,19 217:8,9,17,21 218:11,18 219:1,5 219:7,23 220:1,5 220:7,19 222:2 223:3,6,20 226:18 226:24 234:15 242:5 249:22 286:20 288:19 290:6,16 294:20 carefully 268:10 case 216:15,19,21 217:1 219:20,24 220:1,14 221:9,12 222:15 224:5,6,8 224:13,13 281:3 284:22 285:13 288:11 292:5 293:23 295:10,10 296:6 297:5,10,18 301:9 303:11,16 303:17,19 305:23 306:9,24 307:7,9 308:7 310:8 312:4 315:21 317:9 325:7 327:9 329:19 cases 216:11,12,24 224:11 233:5 250:24 270:6 274:12 306:16	312:9 catch 293:17,18 categories 286:15 327:3 category 251:15 catheter 322:13 caudal 221:17,20 cause 239:17 315:18 caused 319:23 cautious 280:19 CENTER 212:6 certain 257:13 certainly 225:14 234:16 Certified 333:17 certify 333:5 Chagin 291:23 change 313:6 changed 223:2,16 changes 292:15 300:24 channel 313:12 charge 234:20 charting 293:17 301:17 check 292:23 297:2 297:9,20 298:2,10 301:13 302:12,22 checked 291:21,21 296:13,14 308:7 checking 292:18 296:10,16 297:22 300:14 301:3,11 301:18 302:3,19 303:2 304:14 319:8 check-in 238:8 check-ins 238:17 Chicago 212:18 213:4,9 333:7 child 234:7 292:2 child's 234:20 choose 265:16 chose 265:19 chosen 265:15 circulatory 313:1 circumstances	234:24 283:13 cited 235:13 City 333:6 Civil 212:15 claimed 291:21 class 241:24 242:14 242:24 244:1 247:2,23 260:8,8 264:16 classmate 322:3,15 classmates 249:13 249:16 250:21 253:13,20 254:1 258:6 259:5 261:6 262:17 263:23 264:9 267:14 275:13 clear 292:10 clinical 230:6,6 237:8 238:4 249:14 250:12 251:5 252:17 267:22 273:5 275:3,19,23 281:17 clinicals 219:24 220:2 251:22 253:18 267:1 268:8 329:4 close 310:2 closed 298:13 closely 294:16 coaching 244:16,18 245:3,15 cohort 254:2 257:17 266:23 282:8 cohorts 257:8,12 258:13,20 268:16 275:9 282:5 come 237:18,19 238:12 240:9 251:11 253:23 264:17 267:11 coming 230:11 232:19 237:24 240:18 250:19 253:1 276:16
--	--	---	--	---

298:5 commencing 212:19 commended 327:11 comment 238:2 243:8,11 247:1,22 247:24 280:24 281:8 289:1 commentary 228:23 229:12 commented 222:9 comments 231:21 232:3 233:12 235:22 238:22 239:19 244:13 245:9,22 246:12 269:3 280:17 286:17 291:18 329:9 committed 239:9 239:21 common 311:7 commonly 316:21 communicated 220:4 247:13 communication 306:20 313:20 compare 279:9 compared 257:8,12 258:7,20 259:22 275:9 278:23 comparing 239:20 278:16 279:10 compilation 279:21 280:1 complain 254:18 complained 262:1 272:18 complaining 264:17 complete 222:13 273:11,14 280:13 281:17 327:14 completely 225:8 completeness 328:1 complicated 216:13 288:13 component 294:19	concede 293:22 concern 271:14 concerns 249:21 conduct 215:4 confused 276:11 considered 267:20 267:21 consistently 251:14 251:16 252:18 consisting 332:6 consolation 247:17 constant 249:22 292:4 307:21 constantly 307:8 309:5 326:6 contact 301:21 contain 219:1 249:8 280:10 contained 291:16 context 318:9,10 continuation 229:8 continued 212:12 227:8 277:8 continues 229:3 continuous 323:20 contract 248:14 249:2 250:5 252:2 253:4 255:8 269:20 270:19 275:7 control 237:21 296:22 315:4,6,8 conversation 228:4 228:16 229:5 231:24 285:9 306:15 conversations 229:16 231:17 260:9 converted 288:1,5 288:14 convince 320:2 Cook 264:8,11,22 265:2,12,15,17,20 333:2 copies 225:5,6,7,12 226:1,23 copy 216:2 218:22	219:15,18,19 222:14,22 copying 225:4 cord 312:15,15 correct 221:3 255:10 284:24 288:4 290:21 327:11 330:5 332:8 333:10 corrected 330:23 correctly 246:17 327:14 correlate 218:19 304:11 correlated 303:22 correlating 292:8 counselor 261:11 261:11 270:22 271:24 count 292:12 295:5 countered 304:18 County 264:8,11,23 265:2,13,16,17,20 333:2 couple 217:20 222:8,11 262:22 262:22 264:7 273:15 289:14 327:3 course 295:10 296:6 306:4 309:15 court 212:1 332:1 333:6 COURTHEOUX 213:11 Courts 212:16 create 240:22 248:18 criteria 250:23 251:17 critical 233:3 324:8 criticism 258:23 294:1,3 328:2,10 330:15 criticizing 258:19 CRNA 217:10,22 237:23 249:10,13	249:22 250:15 257:19 259:3 262:12 270:9,12 271:8 276:6,19 278:20 291:7,10 291:11 297:2,11 299:6 CRNAs 233:2 236:2 237:1,18,19 238:2 239:15 240:2,18 264:18 264:24 266:6 269:3,10 270:6,16 270:20 272:18 274:3,18 276:14 278:17,24 282:4 291:8 316:4 320:2 327:15 cross 308:11 crossed 307:16 crossing 307:17 crucial 257:17 282:9 312:11 CSR 212:17,24 333:5 cuff 319:8 current 219:6 239:16 cut 237:6 295:14,20 cuts 234:17 CV 282:9 D D 214:1 daily 269:11 data 217:12 date 217:10,13,15 217:18 290:5 291:3 dated 224:20,24 272:24 275:19 280:5 283:23 286:6 291:1,9 320:16,21 323:4 dates 218:17 daunting 310:4 day 217:5 218:11 220:2,5,16 222:2	222:15 224:20 226:15 231:14 251:1,4,5 274:3 275:2 278:5,9,13 278:17 279:11 280:23 281:2 282:22 283:24 284:3 290:5,6,11 290:16 291:8,10 305:12 312:9,12 324:2,10,13,16 325:18 326:2,17 327:17 328:14,23 332:17 days 226:19,24 290:21,22 324:21 325:6 326:3 deal 236:17 dealing 325:1 death 328:23 decide 242:11 243:4 decided 273:22 decision 233:3 234:4 241:10,11 defective 322:4 Defendant 213:12 Defendants 212:10 212:13 215:14 definitely 257:8 308:10 325:9 deflate 318:12,16 319:8 deflated 317:21 deflating 317:12,24 delivered 244:14 department 275:24 depending 302:15 deposition 212:12 215:3,5,23 227:7 227:12 248:8,11 270:23 272:21 275:16 277:7,10 279:14 331:11 332:6,8 333:8 depositions 212:17 describe 228:15,19 286:23
---	---	---	--	--

describes 300:1	discriminated 256:7,10,17,20	302:1	Ebele 265:6,13,19	entitled 277:17
describing 228:10	257:4 258:11	documents 216:2	265:22	entry 329:8
descriptions 236:1	discriminating 255:14 285:21	226:18 281:11	Ed 265:14,19 266:4	envelope 230:22
designed 252:22	discrimination 246:5 254:18	doing 244:6 255:2	editorializing 238:22	232:16
desk 220:14	255:5,23 256:2,3	287:17 288:16	effect 264:20	episode 324:16
detail 257:16	257:1 260:3	301:17,20 302:1,5	302:13	325:18
266:12 312:24	261:21 286:1	327:7,8 333:6	effective 276:22	Erin 212:17,24
details 323:11,17	discriminatory 255:8 258:17	doom 326:7	effects 324:24	333:5
deteriorating 294:17	259:15 330:1,9,16	dosage 313:21	effort 220:7 221:6	error 286:4
determination 236:4	330:19,21	314:5 316:4,9	327:11	escapes 258:7
diagnosis 281:7	discuss 228:1	dose 313:24 314:11	either 223:11 274:7	Essig 262:18
dial 297:12,17,20	266:12 276:18	314:15	283:5	establish 246:16
didactics 243:18	323:12	dosed 327:9	EKG 280:22,23	established 244:13
244:3 263:16,20	discussed 252:5	dosing 329:19	281:2,7,15,22	245:9,20
die 331:13	312:8	Dr 212:7 232:6	292:7,11,23 293:6	ET 317:18 319:7
difference 250:9	discussion 238:4	236:7 253:4,5	294:9	ETT 321:2
278:23 279:5	313:11	255:12,12 256:12	elaborate 238:23	Eva 271:2,7 276:14
different 237:15	disdain 239:9	256:13,18,19	256:5	306:7 320:7,13,20
243:15,20,23	dismissal 251:5	257:10 261:9,16	Elaine 213:3,5	eval 290:11
249:9,15 250:1,7	dismissed 224:23	261:22 264:15	218:22 225:2	evals 267:18
250:13,14,17,20	326:13	267:9 269:14	electronic 222:17	evaluate 247:19
251:8 252:1	disorganized 307:19	270:11,14 276:18	222:22	263:12 268:9
259:10 262:7	disparity 257:9,12	278:14 283:11	eleven-page 220:19	269:5 273:21
264:6 275:8	dispute 220:3	285:8 289:20	eliminate 271:4	274:13 290:15
276:12 278:17,24	287:10 329:10	291:23 326:7	email 262:5 264:15	293:5 325:14
287:20 300:24	330:9	draft 226:9	273:8 274:22	329:4
303:14 304:12	disputed 236:6	drop 232:20	275:18 283:20	evaluated 258:6
327:3	241:1 276:3,9	drug 292:16 300:11	320:13,20,23	278:23,24 285:14
differently 237:20	301:12	300:15 329:18	emailed 221:21	286:4 306:21
238:3 239:16	distinct 286:1	303:15 307:16	emails 262:23	evaluating 269:1
261:4	distracting 303:4	dry 315:13,16	272:23	292:20
difficult 233:18	distribute 274:2	316:1	embolism 286:23	evaluation 217:10
240:3 325:8	275:2	drying 315:5	emotional 236:17	217:11 251:15
dinged 258:1,3	District 212:1,1,16	duly 215:15	236:19 325:23	252:7 254:16
DIRECT 215:18	332:1,1	duration 292:17	326:2 329:6	259:2 273:18
direction 287:3	DIVISION 212:2	300:12,19 301:10	emotionally 325:1	275:3 278:4,9,15
307:11	332:2	302:14 303:12,24	325:7	282:12 283:5
director 250:12	DMR 327:9	304:8,11,14,17	emotions 234:4	284:9,13,17
252:13 269:17	document 216:7	DX 279:23	empty 298:7	285:11,20 286:6,9
disability 243:2	245:21 248:16,18		encounter 313:16	287:4,11 289:21
disagree 288:22	277:15 278:1,5	E	ended 234:14	290:6,24 291:2,15
disagreed 288:20	281:4	E 214:1	287:16 288:9	304:20,22 305:1
discombobulated 309:17	documentation	ear 234:12 318:7,13	306:2	305:14 306:23
discretion 243:19		early 263:24	ends 329:21	312:14 319:7
		easier 244:8	entered 246:23	323:3,8 324:7,16
		EASTERN 212:2	entire 278:15	324:19 325:11
		332:2	entirely 323:15	326:15,21 327:16
				327:24 329:24

330:8 evaluations 235:24 236:3,5,10,14,20 237:1,2,9 252:9 252:13 258:17,24 259:1,7,8,9,16,21 269:10,12,24 270:3,5,9 271:14 273:5,10,11,14 274:3,11,17 275:2 277:18 278:6,12 278:16,20 279:6,9 279:11 280:1 283:2 305:7 event 235:14 285:5 286:12 everybody 285:10 302:20 evidence 246:20 exact 223:3 232:1 exactly 302:18 319:1 321:16 exaggeration 302:4 examination 212:14 214:8 215:18 examined 215:15 example 234:7 239:12 257:14 286:20 324:7 Excel 263:6 exclude 275:23 exclusive 246:9 exclusively 278:13 excuse 325:6 execute 250:5 exhibit 215:21,23 216:2,2 223:20 227:12 248:8,11 272:21,23 275:15 275:16 277:10,12 279:14,16,19,20 280:1 282:14,16 283:18 287:6 290:24 293:21 304:21 320:13,19 323:3 326:21 exhibited 235:19	EXHIBITS 214:16 exited 245:17 expect 253:22 expectation 249:5 249:11 272:18 expectations 248:19 249:2,16 expected 249:12 251:11,24 271:12 272:12 302:14 experience 259:5 289:14,23 299:5 311:9 329:2 experiences 267:22 expertly 253:12 explain 269:17 313:14 318:9 321:15 explained 235:8 266:16 274:20 explaining 233:10 234:24 235:21 237:10 239:15 324:23 explains 278:5 explanation 287:9 313:15 exposed 253:18,23 exposure 271:2,4 expressed 271:13 expressing 239:23 expressions 249:21 extent 329:13 extubated 317:12 318:13 extubating 317:10 319:12 eyelash 257:21 eyes 233:16 F face 307:12 309:14 309:22,23 310:1,5 facilities 265:9 facility 267:15 fact 229:11 237:22 246:20 248:22 273:10 304:17	328:1 factor 244:1 247:15 factoring 240:19 faculty 249:20 255:17,19 256:8 273:14,15 fail 241:4 244:7,9 failed 223:4 failing 330:3,6 failure 251:3,15 fair 253:21 255:18 255:20 271:7,10 273:23 282:1 305:5,8 323:10,15 324:3,8 327:16 330:13 fairly 273:21 Faith 266:23 267:24 familiar 251:20 far 236:5 257:22 263:18 269:5 fast 294:13 faster 302:17 favorable 323:7 February 326:22 327:22 fed 296:23 feedback 274:13 275:4 feel 247:14 257:3 264:19 327:12 feeling 256:17 324:24 326:5 feels 330:20 fell 321:24 322:14 322:16 felt 256:7 326:4 female 298:22 figure 219:8 figured 288:17 filed 223:7 files 281:4 fill 226:15 filled 226:5 find 217:1 218:13 219:7 223:3,5,10 223:11,12,17	241:22 242:2,9 275:6 282:16 305:7 332:7 finish 243:17 finishing 263:20 fires 313:17 first 215:14,21 216:6 219:12 239:9,21 242:8,8 245:1,9,19 262:22 263:8,19 264:16 270:6,23 273:8,18 273:19 280:5 296:9 298:23 301:14 303:20 321:2 327:24 328:23 Fisher 271:2,8 276:14 320:13,20 fit 230:11,17 232:3 232:4 233:16 234:5 236:4 242:3 246:2 five 253:18,23 256:23 302:5 fixed 301:1 flash 308:10 floor 306:12 follow 247:2 270:1 270:11 272:19 283:1 followed 238:3 262:4 following 229:2 249:3 324:16 325:18 follows 215:16 227:9 277:9 follow-up 248:22 284:9 force 231:5 232:17 233:11 234:6 235:23 forced 240:14 foregoing 332:5 333:9 Forester 286:7,10 289:6 290:8,19	Forester's 287:10 form 244:20 246:19 285:24 316:4 format 229:4 formative 251:15 252:9,13 274:11 275:3 forms 226:4 formulate 286:19 found 296:3 four 216:7 256:23 308:2,2 312:20 313:2 324:21 325:6 four-hour 297:5 freak 287:2 289:2,8 289:22 frequently 304:5 fresh 253:6,8,17 freshly 303:21 front 295:23 fulcrum 299:17 full 273:20 298:7 funeral 328:23 further 215:15 243:15 250:17 263:1 fusion 311:2 312:20 G G 213:11 Gallagher 282:8 323:2 gases 301:17 302:2 gather 226:14 gauge 255:13 268:20 325:10 gauged 253:19 general 249:5 250:16 255:18 263:8 267:8 288:2 288:6,14,17 305:19 gesture 309:20 getting 217:3 220:18 257:3 258:6 270:5 274:17 307:15
---	---	--	---	--

310:11 314:24 326:5 give 255:16 269:11 270:13 273:16 given 253:5 266:18 273:11,13 303:21 327:9 332:8 333:8 giving 243:19 302:2 303:15 327:10 gloom 326:7 glossed 258:5 glycol 313:21 314:17 315:1 glycopyrrolate 313:22 314:1,19 315:4,7,16 glycopyrrolate's 315:23 go 243:17 245:14 264:8,22 265:15 265:16,20 267:14 268:1,17,22 269:8 306:1 307:3,3,4,4 317:11,11,11 318:6,6,6,6,8,8 318:12,12,12,12 319:13,13,13 326:16 goes 252:15 283:2 316:7 going 216:10,15,21 222:11 232:20 233:2,5 235:2 237:19,21 238:3 244:11 253:11,12 256:15 264:23 269:8 272:19 273:21 274:8 275:8 276:4,19 288:7,8,16 294:10 295:10 296:18 297:9,13,23 307:10 309:4,5,8 310:3,3 315:13 good 215:2,10 230:11 242:3,15 243:19 268:22 279:9 280:16,17	284:6 296:3 328:14 gotten 274:7 284:23,23 grade 251:18 252:19 graded 253:12 266:6 330:2 grading 253:19 330:12 Gradman 265:14 grand 306:10 grandmother's 328:22 group 218:10 grouped 245:24 guaranteeing 253:16 guess 219:21 220:18 230:1 237:7 239:22 268:15 272:7 274:15 283:11 309:16 312:2 319:5 324:11 328:15,15 329:13 330:17 guide 217:5 218:3 guideline 316:21	H Hakeem 313:16,17 half 224:22 hallmarks 298:21 hallway 229:12 260:8 306:5,12 Halsted 261:16 hand 259:2 299:12 309:24 311:7 316:7,7 318:14,20 318:22 handbook 249:7 251:21,23 275:8 316:5 handed 274:18 handle 325:7 handwriting 291:12	handy 218:6 hanging 320:6 happen 246:13 290:22 301:11 321:8,14 happened 222:24 224:8 228:11,24 261:9 281:20 285:12 289:2 320:9 321:15,19 321:20 322:2,5 326:9 happens 241:16 happy 241:23 242:2 hard 218:22 219:15 219:18 225:4 harder 241:3,5 harsh 258:20,23,24 284:21 330:12 harshly 282:6 283:15 286:4 330:2 hastily 319:6 hear 232:21 242:4 244:20 245:3 heard 232:5,13 244:21 265:21 285:4 289:22 308:2 hearing 259:7 heart 234:3 292:7 292:23 293:6 294:11,13,19 300:16 313:7,12 315:6,24 held 275:14 hello 306:16 help 216:4 233:4,5 300:2 helped 277:20,22 high 297:6 highlight 222:10 highlighted 222:9 highlighting 243:1 hissing 298:4 histories 257:18 268:1 281:5 282:9	history 217:2 226:13 257:14 286:22 312:10,10 hold 308:13 310:16 310:18 311:23 hole 231:3 232:17 233:11 234:12 235:22 237:11 home 231:16 306:1 honest 242:7 273:24 hope 240:18 hospice 315:8 hospital 266:19 hospitals 233:6 264:11,13 hostile 308:23 hour 212:20 224:22 HR 261:23 huge 300:3 human 237:20 hurry 319:14 husband 231:15 277:23 husband's 328:22 HUSCH 213:8	impair 215:7 implication 238:15 important 312:13 impossible 233:18 301:7,8 impression 242:13 improvement 266:21 Inaccurate 291:23 inadvertently 318:13 inappropriate 287:17 295:12 296:6 inches 309:24 310:5 include 217:13 included 328:1 including 276:14 inclusive 332:7 incorrectly 291:9 independence 263:2 indicate 231:19 232:18 238:21 239:1 252:15 304:10 311:22 316:18 328:21 indicated 241:16 244:12 307:2 indicates 252:8 289:3 indicating 240:8 242:13 243:24 257:7 273:9 274:15 275:22 299:19 309:21 individual 212:7,8 212:8 216:12 induces 297:8 information 217:5 224:3 282:5 313:17 327:10 initial 241:15 initially 270:7 injured 312:16,17 inpatient 224:2 insert 296:1 321:10
--	--	---	---	--	--

322:8,11 inserted 322:12 insertions 295:18 insisting 308:3 instances 281:14 299:1 instruct 319:11 insults 237:5 intense 325:10 interact 305:21 interacted 306:19 interaction 306:2 329:18 interfere 293:11,12 interference 292:11 293:10 interpret 299:23 interpreted 242:16 interrogatory 282:17 interruption 253:13,21 intervened 321:1 intervening 294:11 interventions 294:8 introduction 307:16 intubate 288:10 303:20 intubated 288:9,9 intubating 299:9 300:4 intubation 292:3 intubations 280:17 involved 224:22 306:17,20 involves 317:18 in-hospital 224:1 iPhone 221:18 IR 296:20,24 297:1 297:12 irate 308:12 irregardless 329:4 irritated 308:22 issue 234:6 272:12 292:8 294:4 329:5 issues 230:6 235:19 237:9 240:22	289:17 item 257:14 281:11 284:21,24 IV 257:24 291:24 295:15,18 296:1 307:14,17 321:2 330:3 IVs 258:3 280:17 <hr/> J <hr/> Jackson 213:3 Jaffe 311:17 January 248:15 272:24 275:19 277:18 278:2,7,10 279:3,9 280:2,5 282:22 283:23 285:14,21 286:6 286:12 287:10 290:7,18,19,19 291:1 304:21,23 304:24 305:11 306:23 307:7 320:16,21 323:4 325:2,15 jaw 299:17 300:3 Jill 212:8 218:11 219:2 220:4,22 263:12 271:2,7 276:14,21 277:1 278:1,10,19 304:22 305:10,15 305:21 307:6 312:3 320:2 324:17 325:1,18 Jillian 326:24 327:21 Jim 279:1 305:1 job 280:17 284:6 324:1,10,12 Johnson 253:4 254:19 255:12 256:13 270:15 276:18 joke 289:3,7,11 joking 289:9 JOSEPH 213:15 judgment 252:17	281:17 287:20 299:2 judgmental 240:8 240:11 July 262:19 June 218:12 219:1 219:5,8 220:5,20 222:1 224:18 253:7 254:8 262:16,20,21,23 263:8,11,19,24 305:18 <hr/> K <hr/> Karen 213:11 265:6,13,19 266:1 308:21 karen.courtheou... 213:10 Kathleen 257:20 280:9 282:8 283:5 284:16 Keehn 282:22 290:14 291:1 295:1 Keehn's 290:18 keep 219:20 220:7 221:6 275:2 279:16 297:3 322:19 keeping 219:22 Kelly 262:18 282:8 323:2 kept 268:9 308:3 kind 224:21 236:17 236:19 244:15 264:21 303:1 306:14 kit 297:20 Klunk 326:24 327:21 329:9 Klunk's 328:2 knew 256:14 265:2 265:11 289:11 314:15 know 216:19,21 217:18 218:10,17 220:16 223:3,24	224:6,9,18,21 225:4,15 226:21 226:23 227:4 233:4 234:9 235:24 240:20 242:22,23 243:23 253:17 257:22,24 259:2 260:13,18 260:20,21 262:10 262:14 263:1,18 263:20 264:4,13 265:24 266:5,8,14 266:20 267:12,20 268:3,18,19,19 270:18 272:10,11 272:16 274:17 276:16 285:18 288:17 289:11,19 289:23 290:2,3,12 298:7 300:16 302:15,16,18 303:15,21 304:10 304:14 306:5 308:20 310:14 312:1,15,23,24 313:1,5,6,8,10,11 314:5,8,9,20,24 316:4,8,11,14 319:4,5,15 321:17 321:18,24 322:20 323:1,15 324:24 325:10 knowing 316:20 322:1 knowingly 321:12 321:18 knowledge 292:16 300:11 known 287:1 289:10 Kremer 212:7 221:2,24 227:17 232:6 236:7 252:5 253:5 254:20 255:12 256:12,18 256:19 257:10 261:22 264:15 269:14 270:1,11	270:14 272:24 275:19 276:13 278:14 283:11,23 285:8 289:20 320:14,21 326:7 K.B 213:3,5 <hr/> L <hr/> L 213:11 lack 292:6,16 295:2 300:10 laid 220:13 LAND 213:11 214:10 215:2,10 215:19 225:2,8,13 225:15 226:1,4 227:10 228:9 235:4,8,15 242:20 243:3 244:15,20 245:6,10 246:2,9 246:12,18,21 247:1 268:13 272:10 275:15 277:5,12 279:13 279:24 301:7 303:8 304:6 319:20 320:19 326:18,21 331:1 language 228:9 laptop 217:16 218:16,20,23,24 219:6,8,13 223:1 223:4 laptops 218:14 223:2 laryngospasm 286:24 287:2 lasting 303:3 lasts 302:11 late 253:7 254:7 lawyer 218:8 Lea 286:7,9 287:10 287:20 288:22 289:6,19 290:7,14 290:19 305:24 lead 294:7 leading 243:8 256:21 258:10
---	--	---	---	---

leak 298:1,2,11	277:3,4 284:20	298:6	258:24 260:4	mention 261:9
learned 224:6,10	288:13 318:23	MacNeal 264:7,11	270:8 290:15	mentioned 221:11
learning 248:14,19	locate 222:20	264:22 265:2,12	298:20 300:24	229:10 255:7,24
249:2 250:5 252:2	294:13	265:18	306:12 309:12,22	256:1,23 257:4,6
269:20 270:19	location 262:8	MAGNA 212:23	315:7 317:1	257:13 260:2
275:7	264:6 266:17,22	main 266:19	meaning 253:10	261:8,13 265:7
leave 238:5,7,8,11	267:5	268:14	306:15	266:2 267:24
238:13,14,16	log 217:17	majority 323:16	meaningful 306:14	270:17 313:18
239:18 240:14,19	long 302:11	making 236:12,13	306:15	mentioning 257:10
256:22 258:10	longer 288:14	243:8 244:16	means 302:11	mentions 240:24
260:22 261:2,13	301:4 306:15	289:4,13	313:5 330:19	243:15 264:19
261:16,19,23	look 216:24 217:8	March 212:19	meant 217:7,7	messages 274:2,4,6
262:6 276:20,23	218:7 219:13	277:18 278:7	234:6 237:9	met 227:24 256:22
284:8,12 285:5,6	220:23 221:14	332:6 333:9	242:17 247:10	270:14 276:3
Lea's 305:23	223:14,15,17,21	Marcial 212:3,13	250:22 272:15	metabolism 302:15
lecture 298:24	225:3 226:5,22	214:4 215:13,23	289:3,7,9,11	metabolize 302:17
led 304:8	227:11 237:20	226:9 227:8 248:8	290:9,12	302:17
left 221:9 229:9,19	238:3 239:15	272:21 275:16	measure 268:20	metal 300:3
232:19 236:5	271:22,23 279:19	277:8,10,17	mechanism 313:14	MICHAEL 212:7
248:23 284:14	294:7 295:21	279:14 331:12	medical 212:6	Michelle 262:18
295:16,16,21,21	298:5 311:10	332:14 333:8	312:10	middle 229:14
296:1 298:15	327:19	Maricel 212:3,13	medication 215:7	279:6
321:3	looked 217:21	214:4 215:2,13	302:2 313:13	Mike 221:1,24
LEGAL 212:23	218:9 219:4	225:15 227:11	315:7	227:17,18,21
legitimate 294:1	227:13 236:3	248:11 272:23	meet 227:18 228:4	228:6,16,20 229:5
328:2,11 330:15	239:8 293:22	277:13,17 284:3	237:23 252:12	229:16 237:14
letting 242:6	295:16,19 316:23	291:21 305:7	meeting 227:21	238:21,22 239:1
let's 235:11 275:15	looking 226:7	321:1 330:14	228:20,24 229:8	241:13,14,16
279:13,19 304:20	227:21,22 303:4	332:14 333:8	231:16,18,20,21	252:5 254:19
320:12	310:14 320:17	Maricel's 239:3	232:10 237:23	258:9 259:15
level 253:22 298:6	looks 216:6 251:20	mark 275:15	239:2 245:23	260:3 270:1 271:1
leverage 292:4	323:3	279:13 330:3	248:6 253:3,4	271:18 272:24
299:9,24 300:2,6	lost 222:14	marked 214:16	254:19,24 255:6	275:19 276:13
300:7	lot 216:1 236:1	215:21,24 227:12	256:11,13 260:13	283:23 320:13,20
life 234:21	240:21 241:17	248:9,10 272:22	260:15,17 270:18	Miller 279:1 305:1
lift 299:17 300:2	247:15 259:23	275:17 277:11	274:8 276:17	311:19,20,21
lifted 249:6 251:23	260:23,24 287:2	279:15	meetings 250:11	mind 234:3 246:3
light 267:6 289:4	315:18	Mary 254:19	256:21 258:10	mine 218:20 253:22
289:13	lots 292:10 326:12	270:14	260:6,7 276:10	257:17
lighting 293:10	loud 286:17 309:13	mask 292:2	member 292:13	minimum 252:8
limit 271:1,18,21	309:15	matching 217:9	295:5	minor 257:16 286:4
272:2 276:21	lower 323:16	matter 237:22	members 249:20	288:1
299:1	lunch 305:23,24	McCann 311:19,20	254:2 275:24	minutes 292:18
line 273:6	lying 308:3	311:21	membrane 234:12	300:15,21,22,23
list 300:16 312:1		McLaughlin	memory 232:9	301:1,11,15,16
listed 217:22		212:17,24 333:5	316:20	302:3,5,20,23
lists 250:24		MDs 327:15	MENDELSON	304:15,18,19
little 224:4 252:1		mean 248:2 254:1	213:15	307:24

miserable 242:2 mismarked 279:23 misrepresentations 273:20 misrepresenting 307:22 326:3 missed 257:14,17 280:21 281:1,14 281:22 282:8 283:14 284:21 294:15 322:18 330:3 missing 257:24 279:22 misstep 257:23 mistake 239:8,20 292:20 293:1 317:8,14,16 325:20,21 328:6 330:6,18,23 mistakes 241:3 misunderstanding 329:22 330:4 miswrote 291:3 mix 314:2,12,13 mixed 221:12 314:10 MK 229:10 237:24 monitor 293:9 295:6 301:21 303:5 306:6 monitored 288:7 monitoring 292:14 294:4,16,18 month 263:9 306:11 months 250:19 253:18,24 motive 235:6 mouth 315:15 move 242:11,15 250:23 307:11 movements 293:12 moving 237:15 multiple 264:5 281:11 282:5 291:19 309:3 319:18	muscle 302:9 mutually 246:9 myringotomy 234:10,11 M.D 327:10 <hr/> N <hr/> N 214:1 name 290:5 named 312:23 names 218:4,5 Narbone 212:7 247:1,19 248:5 Narbone's 227:20 national 248:6 285:3,22 nature 237:20 310:17 nausea 286:22 288:3,18 297:7 298:22 299:1 near 227:16 278:1 282:21 318:7 nearly 278:13 necessarily 218:4 244:13 245:20,22 259:2 297:3 299:6 330:19 necessary 303:4 308:9 necessity 308:16 need 226:22 233:15 234:18 242:4 252:8,16 266:19 269:9,23 274:12 293:5 297:18 298:19 299:3 301:3 302:12 303:2 308:11,14 311:23 327:12 329:10 needed 267:6 292:4 297:21 300:16 319:21 needle 321:4,10 322:1,7,12 needs 287:2 298:7 317:21 323:19	negative 237:2 285:11 negatives 236:6,6 240:20,24 275:14 neostigmine 314:3 314:10 315:10,17 315:18,20 nerve 242:24 301:22,23 nervous 292:1 network 313:2 neutral 262:8 264:1 neutralizing 315:19 never 236:2 253:20 258:7 267:17 272:17 275:22 315:11 317:13 new 321:8 newer 223:4 night 216:3,16,24 308:6 312:7 Nitrous 291:20 296:11,21 297:6 298:6 noise 298:5 nonsmoker 298:23 non-bolded 228:19 non-satisfactory 257:16 normally 291:9 322:18 NORTHERN 212:1 332:1 Notary 332:20 note 225:3 236:24 285:7 304:13 notes 223:21,24 224:4,12,17,18,19 225:17,21,24 227:14 228:19,23 229:4,8,15 230:5 231:13,20 232:9 235:5 236:21 238:7,10 240:15 244:7 270:22 271:23 280:16 333:10 notice 212:14	250:17 282:10 310:10,13 noticed 217:20 259:4 notification 291:22 no-no 300:3 NRS 251:18 252:19 number 215:21 227:12 248:11 277:13 278:14 279:19 numbers 223:19 316:20 nurse 221:13 233:17 nursing 292:6 295:2 N-2 296:10 <hr/> O <hr/> Oak 262:15 oath 215:4 object 235:2 244:11 296:18 objection 244:15 244:20 245:3,8,10 245:13 246:17,18 304:3 objectives 248:19 249:2 obligations 249:9 observation 268:15 269:1 observations 268:19 obtain 251:16 Occasionally 218:3 occasions 270:4 occurred 287:2 324:16 October 229:23 offer 221:24 222:1 247:16 offered 221:1 offhand 259:17 office 227:19,20 228:4,5,6,14,16 229:10,16,19	260:7 off-site 267:10,14 Oh 279:22 289:8 290:18 okay 218:17 219:15 225:13 226:3 230:4 231:8 233:14 246:21 261:19 277:5 280:3 284:3 287:8 289:10 291:14 292:1 295:19 316:17 321:13 323:19 326:20 328:21 oldest 242:13,14 once 260:21 297:3 ones 219:14 227:2 237:2 278:13 one-on-one 250:15 262:11,16 263:24 264:2 267:6 one-to-one 249:10 249:13 264:12,14 open 233:15 291:20 296:12 297:3,4,23 298:4,10,16,19 299:3,7 opened 296:17 opening 296:22 opinion 230:8,14 236:12 239:22,23 240:2 295:3,7 opinions 236:2 opposed 253:22 optimal 243:22 order 231:19,20 232:1 235:1 244:14 245:21,22 308:15 311:2 312:12 ordered 308:5 organized 232:12 310:9 orient 216:4,5 orientation 262:24 orientations 262:16 origin 248:6 285:3
--	---	---	---	---

285:22 original 225:5,18 225:19 originally 221:11 288:6 originals 225:11 Oskvarek 280:9 283:5 284:16 Oskvarek's 285:8 outline 248:18 outpatient 286:21 287:23 288:5 outside 233:2 244:16 306:16 329:5 overhear 269:3 overhearing 266:5 overlapped 232:2 overseen 264:23 oversight 255:9 256:6 overwhelmed 234:18 overwhelming 234:17 ox 292:7,10,21,23 293:6,13,23 303:5 oximeter 293:12 o'clock 212:20	pages 216:3,7 221:10,10 222:8 222:11 225:3 227:14 283:1 332:7 pair 271:20 272:14 276:4 paired 258:2 264:18 268:16 272:15,17 pairing 276:21,24 palliative 315:8,24 palm 299:15 Palmer 262:18 paper 222:14 316:19 papers 220:11 par 268:18 paragraph 227:16 228:13,14 229:18 229:20,21 235:16 236:16 237:17 241:2,13 274:1 328:13 329:17 paragraphs 237:8 237:13 243:12 paralytic 303:21 308:1 parameters 294:6 294:16 paraphrasing 230:9 parent 295:24 Park 262:15 part 220:10 221:16 229:9,19 235:21 249:1 251:21,22 263:16 288:4 305:9 321:4,10 322:1 329:22 particular 217:8,17 218:13 220:16 224:5 294:12 301:9 303:24 314:9 315:21 particularly 216:12 particulars 224:6 parts 305:13	pass 251:18 passed 302:24 passing 252:19 306:13 patch 286:21 287:14,24 patient 217:2 220:11 221:12 224:2 226:12,13 251:13,17 252:16 257:15 268:6 275:12 281:9,12 288:8,9,10,17 289:15,16 291:22 292:15 294:5 295:13,15,18,24 298:20 299:10 301:18 302:21,22 307:14,17 318:13 patients 224:2 281:5 308:9 315:8 315:24 patient's 224:7 294:17 295:24 299:13 301:22 302:15 312:10 313:6 315:14,14 pattern 257:6 258:19,23 Pay 327:7 pediatric 220:14 221:16 222:7 288:11 pediatrics 315:6,23 peds 289:15 peg 231:2 232:16 233:11 235:22 237:10 people 234:5 241:15 242:4 265:1,5 266:10 268:9 302:16 310:10 325:5 perceived 309:20 perception 299:11 performance 230:7 233:20,23 235:18 235:19 238:4	239:13,16,18 240:11,22 247:19 267:7 274:13 281:13 329:4 performed 217:19 307:4 325:2 performing 281:17 performs 280:13 period 278:6 293:16 325:9 permission 243:16 person 247:2 260:6 262:4 276:8,8,9 283:11 personal 285:7 person's 226:14 persuasive 326:1 pertaining 212:16 pertains 286:2 PETER 213:11 peter.land@husc... 213:9 pharmacology 292:16 300:11 phone 228:3 231:15 phonetic 265:14 291:23 322:3 pick 292:14 pigtail 318:24 pilot 318:23 place 229:23 242:2 242:9 288:15 296:3 321:2 placement 286:22 288:12 places 233:17 264:7 Plaintiff 212:4 213:6 plan 216:9,17,19 217:8,9,17 218:11 219:1,5,7 220:2,5 220:8,19 222:2 223:3,6 233:1 249:14 250:4 266:21 270:24 286:20 planned 224:7 288:10	plans 217:21 218:18 219:23 226:18,24 228:1 312:8 Plaza 212:18 213:8 please 286:18 plus 233:5 239:17 240:19 289:14 297:11 308:14 point 223:16 241:9 245:21 247:14 250:18,21 265:8 279:4 285:16 297:22 301:2 302:18 303:1,17 307:22,23 309:16 330:17 pointed 242:23 321:23 322:15 330:11 pointing 244:24 299:15 330:18 points 287:22 pokes 295:19 policy 269:21,23 poor 233:20,23 poorly 320:3 325:2 port 286:21 288:15 Portacath 288:12 portion 222:14 250:10 positive 236:5 237:2 305:3,8 positively 278:24 possibility 311:24 possible 227:2 242:17,20 243:3 247:9 289:6 299:23 301:19 303:8 320:6 possibly 236:15 276:6 303:1 Post 225:17 postop 286:22 288:3,18 297:7 298:21 299:1 potential 310:19 practice 224:15
---	--	---	---	---

<p>prefer 244:22 295:15 preop 295:14 preoperative 226:16 257:15 280:13,21 281:18 281:23 Preops 280:21 prep 221:17 291:19 preparation 248:15 prepare 216:11,22 prepared 216:14 250:24 251:4,12 preparing 311:12 321:5 PRESENT 213:14 presented 289:13 308:6 312:9 pressure 234:13 294:9 313:8,13 pretty 231:22 249:11,15 261:16 previous 265:20 299:5 previously 252:5 principles 286:24 printed 221:21 prior 226:13 233:23 235:18 238:3 239:13 240:11,21 243:12 249:4 254:15 288:11 289:23 311:3 priorities 312:2 probably 262:23 306:11 probation 248:23 266:24 267:2 problem 249:18 266:18 267:9,11 problematic 267:22 268:1 problems 240:11 249:4 267:16,21 268:8 289:18 291:19 294:17 325:23</p>	<p>procedure 212:15 217:2,19 287:23 288:1,12 294:12 298:9 307:4 procedures 221:17 311:15 proceed 319:21 proceeded 285:11 proceeding 317:9 process 256:2 319:12 produce 223:13 produced 218:8 219:19 product 322:4 profession 236:19 professionalism 252:18 program 230:11,17 232:21 234:5 237:15 240:4 241:15,16 243:2 243:15,17,20,23 247:15,20 248:23 250:12 252:12 268:7 269:18 programs 241:4 246:8 progress 250:12 progressed 263:1 progressing 327:12 progression 301:9 promise 272:20 276:22,24 promised 271:15 prompted 292:8 prompting 287:3 292:4 329:10 promptly 234:19 properly 294:22 301:21 provide 216:10 217:6 249:21 251:12 provided 217:10 providing 294:19 pro-emetic 297:8 Przygodzlek 279:2</p>	<p>283:21 323:5 psychomotor 252:17 Public 332:20 pull 272:8 316:22 319:16 pulled 229:13 316:19 317:1,4,22 317:24 pulse 292:7,9,10,21 292:21,23 293:6 293:11,13,15,23 294:4 303:5 pulses 301:22 purposes 268:7 pursuant 212:14,14 pushing 230:21 232:16 put 224:2 240:14 240:19 266:20 277:16,20 282:10 286:21 307:16 puts 295:22 putting 309:24 P.C 213:3</p> <hr/> <p style="text-align: center;">Q</p> <hr/> <p>qualified 269:4 quarter 269:24 question 215:6 226:17 235:12 237:7 244:24 246:15,19 303:10 305:19 316:16 325:24 329:3 questioning 307:21 questions 216:4 245:1,7 303:14 304:5 307:9 309:11 quickly 319:16,21 319:24 quiz 303:16 quizzed 303:23 304:1 quotes 231:8,9</p> <hr/> <p style="text-align: center;">R</p> <hr/>	<p>race 248:6 259:12 260:3,11,12,16 261:5,13,21 285:3 285:22 286:2 racial 257:4 raise 308:24 309:9 309:12 315:24 raised 309:7 raising 246:18 random 313:17 randomly 308:15 range 300:22 ranked 257:16 282:6 rate 292:7,21,24 293:7 294:4,11,13 294:19 313:7,13 315:6,24 320:3 rated 283:15 327:2 330:6,20 rates 286:14 rating 252:4 280:10 281:16 282:1 283:9 284:23 323:16 ratings 226:20 227:1 252:16 254:11,15 258:12 258:14 264:5 265:3,11,22 266:9 266:11 267:7 275:11 291:16 323:13 326:12 327:3 ratio 314:2 Ray 212:7 227:18 228:1,4,16,20 229:5,16 230:5 237:14,18 239:6 239:12 241:21 247:1,19 248:5 305:24 Ray's 228:5,6,14,16 229:16 read 223:19 225:4 226:2 237:8 251:21 286:17 291:18 327:5</p>	<p>332:5 readiness 236:17 reading 324:12 readings 292:14 293:11 295:6 ready 251:12 297:4 298:8 307:16 realize 233:16 239:6 321:24 realized 293:9 really 218:2,2 219:22 229:11 230:21 232:1 243:10,22 259:5 285:12 290:22 291:4 301:19 308:19 311:4 313:15 314:24 323:12,17 325:13 reason 217:24 220:9 249:1 267:4 304:1 307:20 319:20 325:22 reasoning 330:11 reasons 266:9 reassures 229:11 rebut 283:8 rebuttal 282:11 283:7 289:2 290:4 293:21 316:3,18 323:24 324:1,15 324:18,23 327:19 329:9 recall 221:5 227:13 231:11,24 233:13 248:3 258:21 259:6,17 270:18 270:20 272:13 273:18 274:6,9 282:7 283:13 284:14 290:11,17 293:17 296:8 301:16 302:7 303:10 306:18 313:3 319:1 323:11 328:15 recalling 231:22 receive 275:18</p>
--	--	---	--	--

received 216:3 243:9 247:18 273:9	regression 264:20 264:21	274:19 275:4,6,9	236:22 237:3,9,11	rough 218:2
receiving 257:7	rehashing 231:17	requires 250:4 310:22	238:4,12,14 239:4	round 231:3 232:17
recess 227:6 277:6	related 216:20	residency 249:11	239:10,21,24	233:11 235:22
recognize 243:21	232:13 235:10	250:19 251:22	240:4,12 241:7,19	237:11
248:10 255:10	247:6 251:17	253:2,7,9 254:4,7	243:13 246:4,6,7	rounds 306:10
277:12 289:7	273:5	254:7 263:2,11,14	249:4,23 250:2,5	routinely 256:14
292:7,13,22 295:6	relating 292:20	263:17,21 269:22	250:8 252:4,10,20	Rules 212:15
recognizing 292:21	relaxant 302:9	residents 308:8	254:13 259:21	run 224:21 240:17
recollection 247:5	relevant 254:16	316:21	263:10 266:14	runs 216:7
248:1 303:23	284:22	respect 256:16	271:4,16,19 273:1	Rush 212:6 223:7
319:11	reliable 292:12	response 267:10	273:6 275:24	233:2,7 249:3
reconvene 331:13	295:5	277:17 278:5	277:18 278:6,10	261:3,7,12,20
record 220:17	relief 234:13	279:23	278:17 279:6,11	262:8 264:6
227:10 232:9	remember 215:8	responses 282:17	279:20 280:6	267:23 316:22
245:8	220:12 231:10	rest 222:12 226:15	281:20,23 283:1	320:18 325:14
recorded 254:24	257:9 259:20	249:15 264:9	283:24 284:4,10	329:3
records 220:12	261:1,17,18	result 251:4,17	286:10,15 287:18	
221:12	282:13 305:11,17	295:4	289:12,24 290:7	S
reduced 313:7,7	311:16 314:17	retain 220:13	291:16 293:3,19	S 212:18 213:8
reference 218:6	323:17	retrieve 218:23	293:23 294:23	safe 294:20
227:17 236:13	reminded 325:9	220:10 221:15	295:2,7,19 296:23	safety 251:13,17
237:13 238:11	reminder 290:20	return 228:1 239:3	298:16 302:9,13	252:16 268:6
241:14 242:11	290:23	248:15,20 252:23	304:13 305:3	275:12
243:16,19 246:6	reminds 326:7	266:19 269:8	306:22 307:4	saliva 315:5
252:3 270:24	removed 319:7	270:10,12	309:14,22,23	satisfactory 251:14
278:1 282:22	321:4	returned 261:23	314:8,21 316:11	251:16 252:18
283:4 287:13	renders 278:15	returns 228:10	317:14 318:1,11	323:8,16
299:8 300:10,24	Renee 279:1 283:20	reversal 314:3	318:15,16 319:2	satisfied 313:4
312:24 314:17	323:4 324:2	327:8	320:3 323:8,20	saturation 294:9
327:21	replaced 298:8	review 224:10	324:8,21,21 325:3	save 273:22
referenced 236:11	replied 234:16	250:12 252:13	325:17,19 326:13	saw 261:15 322:15
references 217:4	reported 212:23	281:11	327:3 328:17	saying 218:23
230:6,8 249:20	257:19 273:10	reviewed 282:3	329:22	227:18 230:16
278:9	316:20 320:24	298:23 311:14	risk 297:6	231:10 240:10
referencing 236:9,9	321:9 333:7	reviewing 281:4	risks 298:20,21	242:12 243:21
240:20 242:10	reporter 333:6,17	revise 255:7 290:20	Riverside 212:18	244:9,21 245:4
referred 260:10,11	reporting 283:24	re-insert 321:5	213:8	246:4 249:8,17
260:12,15 313:11	represent 279:20	rhythm 281:10	Rocuronium	254:9 263:22
referring 233:23	reprimanded	right 219:6 220:5	292:17 300:12,15	264:16 265:11
237:8 239:13	257:22	220:20 221:2	300:20 301:3,10	274:4 279:3,5
248:4 281:5,10	requested 272:17	222:3,18 227:14	302:9 303:3,12,24	284:6,8 285:20
316:5	require 310:17	228:1,11,16,21	304:7	290:16 302:19
refers 241:21	required 218:4	229:5,8,17,24	room 245:2,15,18	304:2 309:7
reflective 236:20	264:12,14,23	230:12 231:10	246:24 306:6	311:21 312:6
regarding 239:3	269:22 311:2,6,13	232:10,22 233:12	310:10	313:5,19 315:11
regimen 288:3	requirement	233:24 234:22	rotate 265:9	317:11 318:5
	269:15,19 274:14	235:16,19 236:10	rotation 250:16	320:23 325:6
			263:7,8	330:7

says 227:23 230:2 234:18 236:16 237:17 238:12 250:11 251:3,13 269:21 274:10 275:1 278:12 279:10 280:19 284:2 293:14,22 304:16 308:13 313:8 318:12 319:7 327:24 328:13 329:9	291:24 294:16 295:17 306:5,8,13 308:16 322:13 329:8 seeing 291:22 295:13 seek 271:1 seen 235:24 259:20 259:24 262:17 267:13 305:14 senior 321:6,21 322:14 sense 232:3,4 251:20 255:17 268:6,7 273:20 285:4 308:18 313:15 326:6 sent 262:24 264:10 267:10,23 274:4,9 274:16 305:24 sentence 227:23 237:6 242:8 275:1 293:14 327:24 sentences 242:9 274:10 separate 296:24 sequence 326:3 sequential 246:14 series 227:14 272:23 275:10 283:2 serious 289:5 SERVICES 212:23 session 215:3 set 252:22 255:15 307:14 310:11 setting 316:2 setup 291:19 301:20 309:4 seven 215:22 306:6 severe 266:9 288:18 severity 330:20 shadowing 233:1 Shannon 261:23 262:1 Shanti 322:3 share 222:6	shared 222:7 shares 265:7 sheath 321:3,6,7,11 321:24 322:2,7,14 322:16 sheet 257:15 263:6 short 224:20 shortage 308:15 shortcomings 242:6 258:7 shorthand 333:7,10 333:17 shortly 324:19 show 220:22 221:1 222:2,13 244:7 288:23 317:6 showed 239:3 showing 316:19 Shumpert 261:23 262:1 side 229:11 295:20 299:14 307:17 310:12 SIEGEL 213:3,5 225:7,10,14 226:3 228:7 235:2,6,11 242:19,21 244:11 244:18,23 245:8 245:12 246:4,11 246:15,20,22 268:11 272:8 277:3 279:22 296:18 301:5 303:6 304:3 319:17 320:17 326:16,20 siegeledlaw@aol... 213:4 sign 248:16 323:12 signed 253:4 significant 224:8 294:3,4,19 317:16 similar 220:15 simple 292:14 295:6 simulation 249:14 sine 331:13 single 276:6,7	site 264:1,3 267:1 268:2 291:24 sites 294:14 301:22 situating 302:21 situation 234:16 314:10 situations 234:19 304:12 325:10 skill 253:22 skills 249:14 252:17 264:20,22 268:18 292:6 295:2 skin 273:23 321:4 slipped 322:2 Slow 327:13 small 278:14 smarts 236:18 snapped 307:18 snickering 289:8 soften 247:16 somebody 258:2 273:23 297:6 322:21 sooner 302:16 sorry 235:11 240:6 242:3 246:6 279:22 304:24 316:16 323:14 325:24 329:2 sort 238:22 255:16 289:13 sounds 234:17 252:1 source 292:24 296:21 specific 276:18 specifics 303:15 specified 308:6 specify 308:14 speculation 235:3,4 242:19,21 268:11 296:19 301:5 303:6 304:4 spend 216:1 spinal 311:2 312:15 312:15,19 spines 284:3	spoke 283:10 spread 263:6 spring 248:15 254:5 261:24 square 231:2 232:16 233:11 235:22 237:10 SRNA 249:6,7 251:24 268:7 312:11 SRNAs 216:11 249:9 250:1,7 251:8,19 269:5 SS 332:1 333:1 stack 226:18 stage 262:11 standard 255:15 288:19 standards 233:6,7 268:20 stark 278:23 279:5 start 221:11 253:6 253:8,17 263:7,17 263:21 307:9,15 started 231:15,16 253:7 254:2,4,7 264:16 270:2,6,9 274:17 307:18 startle 309:16 318:8 startled 317:11 318:2 319:4,6,19 319:23 starts 217:8 228:13 249:17 274:1 state 325:23 326:2 329:6 333:1 stated 245:23 statements 235:13 236:2 States 212:1,15 332:1 status 292:15 313:7 stay 291:10 292:19 step 245:2 295:23 stepped 238:22 321:1,6 stimulation 301:23
---	--	---	---	---

stipulate 252:6 stood 295:17 stop 321:23 326:17 326:19 327:6 331:1 stopped 321:22 322:9 stored 219:21 stressed 325:13 326:4 stressful 234:19 struck 242:24 student 248:14 249:7 251:14,21 251:23 252:19 253:20 258:1 269:21,23 275:7 286:19 291:24 292:9,17 293:14 300:14 320:24 321:21 322:8 323:1 students 255:15,18 259:20 262:10 264:4,17 266:19 267:9,11,20,21 268:8,21 269:22 272:16 322:19 studies 298:21 study 224:9 subject 273:6 295:18 subjected 261:21 submit 223:6 274:11 submitted 218:21 252:9 SUBSCRIBED 332:17 succeed 240:3 243:2 success 247:15 successful 241:23 242:10 292:3 suction 315:15 suffering 257:2 suggest 287:18 suggested 269:11	269:13 287:16 308:4 311:13 312:1 suggesting 278:19 278:22 290:13 suggestion 269:18 288:19 suggests 275:5 suite 212:18 213:3 213:8 296:20,21 297:12 supervision 249:22 250:16 262:12 263:24 264:2,12 264:14 267:6 support 323:20 325:22 suppose 241:24 247:22 supposed 255:14 263:7 sure 218:15,24 219:11,12 220:10 221:23 223:16 226:3 227:5 231:14 246:11 249:3 256:6,22 260:12 261:9,15 264:1 266:7 268:5 270:2,11 272:1,2 272:7,10 274:20 283:10,12 285:17 290:17 297:24 301:21 303:22 313:9 327:6,10 330:8 surgeon 288:15,16 surgeons 308:8,8 surgery 224:7 226:14 281:14 288:1,6 298:23 308:13 310:17,21 310:21 311:8,22 312:20 315:2,9,12 Surgical 311:14 surprised 232:21 268:16 suspect 324:2	switched 218:14 sworn 215:1,15 332:17 syringe 318:14,15 318:16,20 319:3 system 253:19 <hr/> T take 269:18 277:4 297:13 327:6,13 taken 212:17 220:11 332:6 333:10 takes 301:23 talk 233:19 238:6 239:19 241:9 244:4 246:5 247:3 259:7 261:3 270:15 282:24 307:5 308:20 310:16 talked 233:21 240:21 244:3,6 260:9,24 267:17 270:19,20 300:17 320:1 talking 232:16 236:8,21 237:14 238:9 241:3,18 242:9 243:4,7,11 243:12 246:6,7 264:9 265:18 276:15 290:14 291:2 306:7 talks 296:9 tank 291:20 296:10 296:11,24 298:1,3 tape 319:8 tasks 327:14 teaching 308:17 team 292:13 295:5 technical 319:20 teenage 291:22 teeth 292:4 299:9 299:13,16,24 300:2,3,6 tell 233:19 256:9,19 257:2 261:3,20	267:4 276:15 285:23 telling 230:9,10 232:20 242:5 244:21 255:2 270:24 tells 251:21 template 226:11 ten 220:19 222:13 302:23 307:24 ten-page 221:17 term 252:10 255:24 terms 252:22 263:2 265:18 281:13 308:18 314:2 328:6 330:2 Terrebessy 261:9 270:23 271:24 testified 215:15 272:5 276:12 313:18 testify 215:8 testifying 245:11 245:12 testimony 244:12 333:7 text 274:1,4,6 textbook 311:22 texts 274:9 Thank 246:21 theirs 233:3 theme 238:23 264:21 therapist 261:10 thing 220:12 221:15 225:2 231:23 233:15 236:18 268:14 294:7 324:15,18 things 224:10 230:16 232:15 235:15 236:22 244:3 245:19 246:10 256:16 258:5,12 259:4 260:23,24 282:3 303:5 308:17 312:11	think 217:16 218:19 219:22 221:9,14 223:15 224:19 225:17 229:3,10 230:10 230:17 232:18,24 234:3 236:1 237:14 238:10 239:17 240:13 241:14 243:3 247:6,9 249:5 250:19 253:21 254:9 255:24 256:21 260:16 261:8,12,16,22 262:4,22 263:11 264:21 265:19 266:5,6 268:14,22 269:4 270:17,18 273:15 274:6,21 280:19 281:8 282:15 283:6,10 284:16,18 285:1,2 285:10,16 286:3 287:13 288:6 289:10 290:9,19 291:3,4 293:16 297:9 299:3,9,15 301:14,15 302:3 303:19 304:21 306:22 307:24 309:15,18 311:20 312:20 318:11,21 319:23 320:5,8 323:23 325:5 327:6,18 330:10 330:14,24 331:1 thinking 291:8 322:12 third 227:16 278:4 278:12 305:14 thought 219:4 220:3 232:18 237:10 256:2,9,20 257:2 258:11,17 259:9,14,15 261:3 261:20 268:21 282:13 283:15
---	---	--	---	---

284:20 289:7 295:11 296:6 298:15 312:3,12 320:1 330:1,2 three 216:7 221:10 250:19 262:17 263:22 266:2 267:13 292:18 301:11,16 302:3 302:20 304:15 305:20 306:11,21 312:20 three-hour 303:19 three-minute 293:16 three-week 263:21 throat 317:19 time 216:1 217:17 220:1 222:21 232:7 237:4 238:16 242:1,15 242:23 259:19,24 260:1 277:4 278:6 289:15 290:10 300:17 301:24 302:21 303:9 305:22 310:7 316:8,23 319:10 319:14 323:23 327:6,14 times 217:20 218:1 256:23 257:13 276:12 289:15,16 305:20 306:11,19 306:21 309:3 319:9,18 timing 243:22 244:6 247:4,7 304:7 tips 224:9 today 215:7 228:1 284:3 321:2 told 232:24 233:8 236:3 237:23 253:3 258:16,18 258:22 259:15,18 259:19 270:11 271:1,24 275:23	276:4,13 288:18 289:20 297:8 304:17 312:3,6,11 314:11 319:9 321:7 322:20 top 217:22 220:13 249:18 274:22 281:8 291:12 293:22 topics 246:1 touch 299:21 touched 299:12,12 299:14,19 tower 306:6 tracing 292:10 training 250:21 253:14 transcript 332:5,8 333:10 transfer 223:4 241:10,15 243:5 246:7 transferring 241:19 transgress 310:19 transition 241:4 243:14,19,23 247:4,7,16 transitioned 244:6 247:17 transitioning 243:13 treated 253:11 259:16 261:4 treatment 257:7,9 257:12 286:23 treatments 255:9 287:1 tried 220:22 223:15 231:11,23 273:21 307:13 322:23 tries 324:2 trigger 294:13 true 267:12,20 273:13 276:2 293:5,15,18 322:22 328:5,7,14 332:8 333:9	truly 241:23 trust 327:11,15 truth 242:4 try 225:7,14 226:23 233:17 242:2 271:18,20,21 272:13 273:22 276:21,24 321:10 321:13 322:17,21 trying 221:7,22 222:20 241:9 258:21 259:6 270:17 276:7 294:12 307:14 309:3,18 310:9,15 318:14 320:2 322:8,19 326:1 tube 317:18 Tuesday 212:19 turn 223:18,20 270:2 277:24 282:19 283:17 287:6 297:12,17 297:18,20,20,23 298:10 304:20 305:10 320:12 turned 255:16 turning 279:4 twenty 302:23 twice 266:24 273:19 twilight 288:8 twitches 292:18 300:14 301:3,11 301:13 302:3,12 302:19,22 303:2 304:15 307:23 two 218:14 219:23 221:10 223:2 237:7,13 242:9 246:12 257:17 264:11,13 266:5 274:10 278:24 282:9 284:3 291:8 297:13 304:11 306:21 319:9 twos 278:14 tympenic 234:12	type 217:2,4 226:14 308:11 310:21 311:7,22 typed 227:14 308:10 <hr/> U Uh-huh 265:4 Unable 286:19,23 undermined 295:23 understand 221:8 221:22 265:10,10 270:8 291:14 304:8 313:19 318:9 330:8 understanding 245:24 253:8 256:12,14 269:9 271:6,9 276:20 298:18 unfair 330:16 United 212:1,15 332:1 university 212:6 267:11 unprofessional 295:11 296:7 307:6 unreliable 294:10 unsatisfactories 227:3 264:10 265:8,15,21 unsatisfactory 226:20,24 252:3 254:10,15 258:4 258:12 264:5 265:3,11,22 266:8 266:10 267:7 275:11 278:15 280:10 281:16 282:1 283:8 286:14 291:16 325:12 326:8,10 326:12 327:2 unsuccessful 230:12 321:3 unsure 329:10	untoward 285:12 unusual 284:4 uphill 239:7,20 upset 242:3 Uremovic 257:20 use 297:4,6 299:4 300:5 314:1,2,9 315:1,6,10,11,16 315:17 316:9 318:16 319:3 uses 315:23 usually 217:12 224:16 316:6 <hr/> V valve 298:5 various 278:5 veering 315:22 venous 286:23 ventilation 292:2 ventilator 308:18 verbal 252:3 verbally 308:23 verbatim 231:9 verify 317:3 version 222:17 vessel 310:20 vessels 312:16,16 312:18,21 313:3 Vic 285:7,11,14 view 296:16 325:5 visualize 299:18 voice 308:24 309:7 309:10,13 vomiting 286:22 288:3,18 297:7,8 298:22 299:1 vs 212:5 <hr/> W W 213:3 waiting 244:8 walked 285:9 want 215:21 216:1 223:18,23 245:2,4 245:6,8 246:16 265:10 268:8 282:24 295:17
--	--	--	--	---

321:17,18 322:17 322:18 330:7 wanted 227:18 228:4 247:14 284:9 286:20 312:24 313:13 314:5 wants 295:20 warning 252:3,4 wasn't 222:12 223:12 236:4,14 245:20 254:7 257:22 273:21 276:19 281:9 282:10 287:17 289:5 293:8 296:12 300:7 306:9 310:21 313:3 waste 242:1 watch 293:6 298:24 327:13 way 217:9 242:12 242:22 247:13 253:12,13,14 257:11 259:16 289:9 300:1 306:20 310:15,20 315:20 316:15 319:5 321:9 330:1 ways 232:12 276:12 weak 286:19 week 239:2 263:18 263:19 274:2,8 328:22 weekly 250:11 252:13 weeks 232:19 262:23 welcome 246:22 went 221:14 228:6 231:17 261:19 262:6,15 265:19 270:23 288:12 289:20 weren't 276:4 294:10 297:23 we're 216:10 229:2	238:18 274:7 301:17 303:15 306:12 311:2 326:16 white 257:8,12,17 258:13 wife 285:8 Wiley 267:9 Wimberly 212:8 218:11 219:2 220:4,23 263:12 271:2,7 276:14 278:2,10,20 304:22 305:11,15 305:21 320:2 324:17 325:1 wish 234:2 witness 214:4 215:1 215:9 228:8 244:11 245:17 246:23 258:3 320:24 witnessed 232:6 wonder 290:18 wondering 217:14 221:7 232:12 319:22 word 234:9 words 228:19 230:19 231:8 244:21 324:12 work 220:13 221:13 231:5 232:17 233:2 235:23 248:19 254:16 262:7,17 263:23 264:6 266:17,21 269:2 270:16 271:14 274:3 322:23 worked 218:11 219:2 261:7 284:2 284:2 297:1,11 305:20 working 216:15 worksheet 220:15 221:16 222:8 worried 275:11	worth 278:16 279:10 wouldn't 220:23 266:16 267:5 271:12 287:24 wrist 299:12,21 300:5 write 218:4,5 224:4 231:13 233:15 234:16 241:22 259:3 277:15,21 282:11 290:5 324:1 writes 274:22 280:16 304:13 311:16 312:14 write-up 296:9 writing 262:3 307:19 329:14 writings 307:3 written 232:9 252:4 259:9,16,21 290:5 290:7,16 wrong 246:19 300:22 wrote 230:1 266:10 295:4 316:3,5 323:19 324:3,4 325:17 327:5 328:3,7,17,19	years 218:18 219:23,24 yelled 318:6 young 298:22 youngest 241:24 242:24 243:24 247:2,23	229:22 238:18 275:19 278:2,10 279:9 301:15 304:21 305:11,18 306:23 307:7 20th 219:8 279:4,7 324:19 2013 218:12 219:1 219:5 220:5,20 222:1,21 224:18 229:24 254:5 263:13 305:17,18 320:1 2014 261:24 269:8 273:3 275:19 277:18 278:2,7,10 278:21 280:2,2,6 283:23 285:15,21 286:12 287:11 290:7 291:1 304:21,24 305:11 306:23 320:5,21 323:4 326:22 327:22 2018 212:19 332:6 332:18 333:9 21 229:7 290:7 214 332:7 215 214:10,18 22nd 320:16,21 2200 213:8 24 229:23 323:4 24th 279:2 325:2,15 248 214:18 27 282:19 272 214:19 275 214:19 277 214:20 279 214:20 28 252:8 269:23
		zero 308:1		
		1		
		1st 262:19,21 10 214:19 263:12 275:16 301:15 305:17 11 214:20 277:10 277:13 279:16,23 282:14 287:6 1100 212:18 12 214:20 279:14 279:19,20 280:1 283:18 290:24 293:21 304:21 320:19 323:3 326:21 120 212:18 213:8 292:9 293:15 1243 226:9 13 283:23 15 282:22 286:6,12 287:10 290:18 291:1 15th 290:19,19 16-cv-06109 212:5 17 230:2 272:24 304:24 17th 279:1 291:4 175 216:3 18 227:13 228:8 229:14 231:9 19 272:24		2
		2 310:5 20 218:12 219:1,5 220:5,20 222:1 224:18 229:3,15		3
				3 282:16 293:21 300:15 309:24 310:5 327:22 3rd 326:22 3:00 277:3 312.526.1631

213:10 312.583.9970 213:4 329 332:7 35 300:23				
4				
4 287:6,9 290:4 4:30 326:17 40 300:21 301:1 304:18 405 213:3 45 300:22,23 304:19				
5				
5 277:24 301:15 53 213:3				
6				
6 212:19 227:12 316:5 332:6 333:9 600 251:18 252:19 60604 213:4 60606 213:9				
7				
7 214:18 215:23 216:2,2 316:18				
8				
8 214:18 248:8,11				
9				
9 214:19 272:21,23 323:24 327:19 9th 280:5 285:14,21 9:30 212:20 98 320:18				

EXHIBIT

A18

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

MARICEL MARCIAL,)	
)	
Plaintiff,)	
)	
vs.)	No. 16-cv-06109
)	
RUSH UNIVERSITY MEDICAL CENTER;)	
DR. MICHAEL KREMER, in his)	
individual capacity; RAY NARBONE,)	
in his individual capacity; and)	
JILL WIMBERLY, in her individual)	
capacity,)	
)	
Defendants.)	

The continued deposition of
MARICEL MARCIAL, called by the Defendants for
examination, pursuant to notice and pursuant to the
Rules of Civil Procedure for the United States
District Courts pertaining to the taking of
depositions, taken before Erin McLaughlin, CSR, at
120 S. Riverside Plaza, Suite 1100, Chicago, Illinois,
on Monday, March 19, 2018, commencing at the hour of
1:45 o'clock p.m.

Reported for
MAGNA LEGAL SERVICES, by
Erin McLaughlin, CSR

Page 335

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14 MR. PETER G. LAND and MS. KAREN L. COURTHEOUX,
15 appeared on behalf of the Defendant;

16 ALSO PRESENT:

17 MR. JOSEPH MENDELSON.

18 * * * * *

Page 336

1 I N D E X

2 THE WITNESS: MARICEL MARCIAL

3 PAGE

4 EXAMINATION BY:

5 MR. LAND 337

6 EXHIBITS MARKED:

7 No. 20 369

8 No. 21 393

Page 337

1 MARICEL MARCIAL,

2 Called on behalf of the Defendants, having been
3 previously duly sworn under oath, was examined and
4 testified further as follows:5
6
7 DIRECT EXAMINATION (Cont'd)
8 BY MR. LAND:9
10 Q Maricel, I've handed you what was
11 previously marked as Deposition Exhibit 12 to your
12 deposition. We were going through that last time.
13 I hand you what's marked as Exhibit Number 3 which
14 were your interrogatory responses which we were also
15 using before, and Exhibit 11 which were your 2014
16 rebuttals. Do you remember those documents?

17 A Yes.

18 Q Would you turn in Exhibit 12 to what's
19 marked Rush 91 at the bottom. Does this appear to be
20 an evaluation dated February 14?

21 A Yes.

22 Q From Renee Prygodska?

23 A Yes.

24 Q Does this re-evaluation rate you in all

Page 338

1 categories as satisfactory or outstanding?

2 A Yes.

3 Q Is this evaluation fair?

4 A I recall my performance that day. I felt
5 she rated me fairly, and even I recall her comment
6 that despite the complicated setup I was able to keep
7 up on my own.

8 Q So is it a fair evaluation of your work?

9 A Yes.

10 Q If you could turn to the next page which
11 the next three pages are an evaluation prepared I
12 believe of you by Judy Wiley --

13 A Yes.

14 Q -- from a case you worked on on
15 February 13; 2014; is that right?

16 A Yes.

17 Q And under Psychomotor Skills, II,
18 paragraph D, it appears Dr. Wiley rated you below
19 level expected; is that right?

20 A Yes.

21 Q And there is a reference there to dosing
22 an epidural?

23 A Yes.

24 Q Using "5 of Lidocaine"; right?

Page 339

Page 341

1 A Yes.
 2 Q Then it states: When Maricel went to
 3 re-dose, she gave .5 milliliters; and in this case 5
 4 milligrams. To me this indicates she does not know
 5 the usual doses of local anesthetics. And if she did
 6 not understand, she did not ask for clarification.
 7 Both are problematic behaviors? Do you see that?
 8 A Yes.
 9 Q Was that accurate?
 10 MS. SIEGEL: Where are we?
 11 THE WITNESS: Right up here.
 12 MS. SIEGEL: What page?
 13 THE WITNESS: 89.
 14 MR. LAND: Q So my question is: Is that
 15 statement by Dr. Wiley accurate?
 16 A No.
 17 Q Did you give .5 milliliters?
 18 A I did. But I explained to her what my
 19 thinking was; and I think from my recollection I told
 20 her that from my previous case, I had that mind set.
 21 And so I had a little confusion which I intended to
 22 correct or clarify with the resident, but that
 23 conversation didn't make it to this evaluation.
 24 Q So it is accurate you gave .5 milliliters

1 Q So you're saying that her narrative that I
 2 just read is true, right, from Exhibit 12 from her
 3 evaluation of you February 13, 2014?
 4 A Yes.
 5 Q Did you say that's true?
 6 A It's true that I did give that amount, but
 7 her translation of my understanding of the dosing that
 8 I was supposed to give was not entirely accurate. So
 9 I agreed with the amount that I did give. She was
 10 correct with that. But I dispute her conclusion that
 11 I didn't know the proper dosages.
 12 Q Okay. So your rebuttal says that this
 13 narrative is true; right?
 14 A That I did give that amount is true.
 15 Q That's not what I'm asking. I'm saying it
 16 says that the narrative in this section is true; and
 17 the section we're looking at that I read, that's what
 18 you were referring to; right?
 19 A Yes.
 20 Q And then later in your rebuttal in that
 21 same paragraph you indicate: Still I concede this was
 22 in error?
 23 A Yes.
 24 Q Right?

Page 340

Page 342

1 in that case?
 2 A Yes.
 3 Q And that the black resident had suggested
 4 a re-dosing of 5 of Lidocaine; is that right?
 5 A Yes.
 6 Q Could you look at what's been marked
 7 Exhibit 11?
 8 A Okay.
 9 Q And turn to Page 10.
 10 A Yes.
 11 Q There is a reference here to Judy Wiley,
 12 February 13, 2014. Do you see that?
 13 A Yes.
 14 Q So it's referring to the same evaluation
 15 date that we're just looking at; right?
 16 A Yes.
 17 Q And it indicates Section 2, Part D. Do
 18 you see that?
 19 A Yes.
 20 Q And it says: Dr. Wiley's narrative in
 21 this section is true, but I dispute her conclusions
 22 that I did not know the proper dosages. Did you write
 23 that?
 24 A I did.

1 A Yes.
 2 Q So you made a dosing error?
 3 A I did.
 4 Q And then you wrote: This was my first day
 5 with Dr. Wiley being one of the all important
 6 evaluations, and I was very nervous in that stressful
 7 environment; right? You wrote that?
 8 A Yes. I wrote that.
 9 Q Was there anything Dr. Wiley did during
 10 that session that made you nervous other than being
 11 there and evaluating you?
 12 A I was nervous of her, how she would
 13 perceive me because when I am with her, she usually
 14 has an iPad with her; and I know that she is
 15 contemporaneously writing down the evaluation.
 16 And so for me I was nervous with that
 17 prospect of being a constant observation, not
 18 necessarily that situation that I was in, I mean not
 19 necessarily that the case made me nervous. I knew
 20 that I was under scrutiny; and it made me nervous, her
 21 I guess interaction. That's what I recall.
 22 Q So it was the fact that she was evaluating
 23 you that made you nervous?
 24 A Part of it, yes.

Page 343

Page 345

1 Q Was there anything else she did that made
2 you nervous that day?

3 A No. I don't remember. I don't recall if
4 there is anything else.

5 Q If you look in the evaluation of Dr. Wiley
6 from that day in Exhibit 12, Rush 89 --

7 A Yes.

8 Q -- under Clinical Judgment, III, under B
9 and D, she rated you as below level expected; right?

10 A Yes.

11 Q And did your rebuttal address that at all?
12 I'm asking about your rebuttal.

13 A Okay. I'm just trying to see. I don't
14 see whether I addressed that.

15 Q It's not listed anywhere, is it, on
16 Page 10?

17 A Not that I see.

18 Q Do you know why you didn't address those
19 ratings in your rebuttal?

20 A I am not sure that I saw this
21 contemporaneously and recall how to address these two
22 items. It's either I missed it and could not recall
23 what I was thinking in relation to these two items, so
24 I think we tried to do a rebuttal based on what I

1 done multiple modifications that I'm not sure which
2 ones when we submitted like this one especially.

3 Q If you turn within Exhibit Number 12, if
4 you turn to what's marked as Rush 84, is this an
5 evaluation of you by Dr. Wiley from a case you worked
6 on on February 18, 2014?

7 A I think this is -- I'm thrown off by these
8 dates here. It appears that, yes, this is her
9 evaluation of me.

10 Q On the case of February 18, 2014?

11 A Yes.

12 Q If you could turn to the second page under
13 III, Clinical Judgment?

14 A Yes.

15 Q Under paragraph E there it rated you as
16 unsatisfactory; isn't that right?

17 A Yes.

18 Q And there is reference there to you
19 labeling a syringe in a certain way?

20 A Yes.

21 Q And then reference to the amount that you
22 actually gave to the patient?

23 A Yes.

24 Q Do you see that?

Page 344

Page 346

1 recall from this encounter.

2 Q So you don't recall anything about those
3 two items that we're looking at in Paragraph 3 B and
4 D?

5 A I don't recall it, and most of the time
6 Dr. Wiley would call me and we'd go over her reasoning
7 for grading me in those items. And I mean these are
8 three pages, and sometimes our phone conversations are
9 just like some certain parts of it. So I don't think
10 we went through this from my recollection.

11 Q When did you write Exhibit 11, your
12 response to evaluations between January and March of
13 2014?

14 A I don't recall the exact dates, but I
15 imagine before my appearance with the appeals
16 committee I think at the university from the best that
17 I can recall.

18 Q So after you had received your failing
19 grade?

20 A Yes.

21 Q And is that the first time you submitted
22 this rebuttal, what's marked as Exhibit Number 11 as
23 well to anyone at Rush?

24 A As far as I can remember. I think we have

1 A Yes.

2 Q Are those statements correct in that
3 paragraph of this evaluation?

4 A Partially. So it is correct that I did
5 write .2 milligrams. I don't know why. But I did
6 give the accurate amount that I was told to give
7 despite the mislabel. The only issue there is that I
8 mislabeled it, but the dose and the type of drug was
9 correct.

10 Q So you mislabeled the syringe?

11 A The drug name is right. The writing on
12 the concentration of the drug is the only thing that's
13 incorrect.

14 Q And that incorrect information was on the
15 syringe label; right?

16 A Yes.

17 Q Did you also chart it incorrectly?

18 A No. I charted that I gave 10 milligrams
19 as instructed. So this is just the sticker which
20 sometimes it's optional that we write the
21 concentration of the drug there because it's mainly a
22 guide; but I gave the correct amount, the correct
23 drug, for the correct intention.

24 Q Did you think that it was unfair to rate

Page 347

1 you as unsatisfactory because the syringe was labeled
2 incorrectly?

3 A I think, yeah, it was unfair that it was
4 just that one portion. But the medication was
5 identified correctly, the dose, the amount; and the
6 intention for it were done correctly. But I was
7 dinged for that one slight which did not affect the
8 patient's condition except improve the condition that
9 the patient was in. He was hypertensive, and I was
10 able to relieve that.

11 Q How do you know when you were
12 administering that drug and that syringe what the
13 concentration was in the syringe?

14 A Because the vial tells me; and I guess
15 when I flipped it, instead of 20 because it's 20
16 milligrams per ml for the Hydralazine, so I must have
17 got dyslexic and thought it's .2 instead of 20
18 milligrams per ml that I should have written. But I
19 work with that drug in the ICU constantly, so I'm
20 familiar with that kind of drug.

21 Q When did you prepare the syringe for this
22 case? Was it before the case had started?

23 A No, right there because this is one of
24 those as-needed drugs. So when that situation arose

Page 348

1 where the patient was hypertensive, she told me --
2 First of all, actually I called Dr. Lai and informed
3 him that the patient was hypertensive, can I give
4 Hydralazine, and he agreed. So that's when I pulled
5 out the vial and drew up the drug, labeled it right
6 there as I'm about to like give it because the blood
7 pressure was rising steadily.

8 So I guess in the haste I didn't label
9 it accurately; but it was the right sticker for the
10 right drug, and I gave the right amount. So I
11 prepared it right then.

12 Q Could you turn to what's marked in
13 Exhibit 12 Rush 82. Is this an evaluation of you by
14 Heather Keldahl --

15 A Yes.

16 Q -- from a procedure on February 20, 2014?
17 Is it?

18 A Yes.

19 Q And this evaluation rated you
20 unsatisfactory in several categories, right, two
21 categories?

22 A Yes.

23 Q Do you remember this day?

24 A Just parts of it. I guess I remember the

Page 349

1 machine.

2 Q Which machine?

3 A The Neptune and irrigation that she puts
4 down here.

5 Q Do you see in the handwriting at the
6 bottom, a couple of sentences into it, it says: Needs
7 to speak up when sterile field is contaminated?

8 A Yes.

9 Q During da Vinci she accidentally -- I
10 don't know what it says after that?

11 A She accidentally hit sterile robot arm
12 after dumping urine from Foley. She did not tell
13 anyone. I observed it and informed the nurse so it
14 could be properly covered. I think maybe with the
15 printing it got, something got erased. This is a
16 patient safety issue. Mistakes happen, but you
17 something -- This is half.

18 Q So did you bump into the da Vinci arm that
19 day?

20 A Yes.

21 Q Is it accurate that that created an issue
22 for a sterile environment situation?

23 A Yes.

24 Q And did you tell anybody?

Page 350

1 A What happened was when I was emptying the
2 Foley, as I was getting up, she called me; and when I
3 turned around, that's when I bumped the da Vinci arm.
4 So she saw me hit it.

5 I looked around. The surgeon was busy
6 manipulating the robot arm. I looked around for the
7 circulating nurse to alert them; and I think she had
8 stepped out on the side, so I couldn't find anybody
9 except tell Heather, What do we do now? And so she
10 witnessed me bumping it; and I looked at her, looked
11 around for somebody to remedy it; and I approached her
12 like, What do we do now?

13 So it's not true that I tried to hide
14 this. She witnessed me bumping it. I saw her saw me
15 pumping it; and because she distracted me is how I
16 bumped it.

17 And shortly after the circulating nurse
18 came back, and she was the one who informed the
19 circulating nurse; but I never intended or I was never
20 hiding it. It was in her plain view.

21 Q Did you tell the circulating nurse?

22 A She approached the circulating nurse
23 because she saw first coming back into the OR suite.

24 Q So you're saying there was no one you

Page 351

1 could tell at the time?

2 A Except Heather because she was watching.
3 She saw this. So I asked her, What do we do now?

4 Actually I think I went over this with
5 Dr. Kremer; and he said, Why didn't you tell the
6 surgeon? I said, He was busy operating the robotic
7 arm, and I didn't want to distract him. I didn't know
8 at what point he was snipping anything. The robotic
9 arms are inside the patient; so if I even tapped him
10 or distracted him, I worried that I would startle him
11 or cause an error while he's operating it.

12 Q Can you turn to Rush 80 in Exhibit 12. Is
13 this an evaluation of you by Eva Fisher from a case on
14 February 25, 2014?

15 A Yes.

16 Q Did this give you unsatisfactory ratings?

17 A Yes.

18 Q Several of them; right?

19 A Yes.

20 Q If you could, look at Exhibit Number 11,
21 your rebuttal document.

22 A Okay.

23 Q On Page 13 of that, it ends; and I don't
24 see any reference to this evaluation from Eva Fisher;

Page 352

1 is that right?

2 A Yes.

3 Q And do you know why you didn't include a
4 rebuttal of this evaluation of Eva Fisher?

5 A I don't recall. I'm not sure if I had
6 received this entirely. Yeah. I don't remember why
7 we didn't do a rebuttal on this one.

8 Q Okay. So in the handwritten comments,
9 there was language that states: Maricel is still
10 having problems prioritizing. Do you see that?

11 A Yes.

12 Q She was trying to chart while the block
13 was placed instead of watching the block and
14 caring for the patient. Do you see that?

15 A Yes.

16 Q Did that happen?

17 A Yes.

18 Q She was able to recognize changes in
19 patient's --

20 What is that?

21 A Hemodynamics I think.

22 Q But was constantly and unnecessarily
23 fidgeting with the VA. Do you see that?

24 A Yes.

Page 353

1 Q Was that accurate?

2 A I don't recall that happening.

3 Q What does that mean, you don't know if it
4 happened?

5 A I don't remember that it happened that
6 way, the way she described it. What I recall was the
7 case was uneventful and she didn't really talk to me
8 about this evaluation for me to remember exactly which
9 particular issue she was pointing at here.

10 Q Well, she identifies it here, right, this
11 particular issue, recognizing changes; and you were
12 instead constantly and unnecessarily fidgeting with
13 the VA. Do you remember how much you were adjusting
14 the VA?

15 A Ventilator. I'm not sure.

16 Q You don't know what the VA is?

17 A I'm not sure if that she means the VA as
18 the ventilator. Yeah. I don't remember doing that.

19 Q Are you saying that she is false in saying
20 that you did or you don't remember?

21 A I just don't remember. Like I said, she
22 didn't discuss this with me to point out exactly what
23 she was trying to criticize me about.

24 Q I'm just asking what you remember about

Page 354

1 that, not what she said to you?

2 A I don't remember fidgeting with the vent a
3 lot and fighting. I think if I saw like the
4 anesthesia record, then I would probably be able to
5 recognize or determine what she was talking about.

6 Q Reviewing the anesthesia record would help
7 you remember what you did with respect to fidgeting
8 unnecessarily with the VA?

9 A I don't know what she meant by unnecessary
10 because we're always going back and forth adjusting
11 gases, looking at the patient, maybe giving
12 medications.

13 Q What would the anesthesia records show you
14 about that?

15 A There is a section that shows what modes
16 of ventilation setting, if I was changing it; but if
17 it's consistently the same parameters, then that
18 disproves her claim that I was fidgeting with it a lot
19 because you could switch from volume control to
20 pressure control ventilation to pressure support if I
21 wanted to modify something as she was claiming here.

22 But I just don't recall that I was
23 making changes a whole lot, or I could also write the
24 concentration of gases that I was changing it to in

Page 355

1 the anesthesia record if that's what she was trying to
2 say here.

3 Q That isn't what it says, is it?

4 A Well, it's the ventilation and machine; so
5 if I'm adjusting gases, then I would also be recording
6 that on the anesthesia record.

7 Q Okay. On the second page of this
8 evaluation from Eva Fisher, it says, Maricel does not
9 know how many hours --

10 What is that?

11 A Propofol.

12 Q -- Propofol follow can be in a syringe
13 before it expires?

14 A Yes.

15 Q Did she ask you about that?

16 A Yes. She did.

17 Q And did you know?

18 A I did.

19 Q Did he tell her?

20 A I gave her an answer. I said that I'm not
21 entirely sure with Propofol in a syringe, but I could
22 tell you that in a drip tubing it lasts for 12 hours.
23 But being that there is a quick turnover and Propofol
24 is not used on a lengthy case, I'm going to be

Page 356

1 conservative in saying it's only six hours before we
2 decide to draw a whole new vial because this might not
3 be good anymore. So I gave her an answer, and so this
4 is inaccurate that she said I did not know.

5 Q Your answer was?

6 A Six hours.

7 Q You knew how long in a tube but not in a
8 syringe?

9 A Yes.

10 Q Did you say you weren't sure in the
11 syringe?

12 A I wasn't sure in the syringe, but I told
13 her my reasoning or my thought process as to why I
14 think it should be half of that or a more conservative
15 estimate because, you know, it's usually a quick
16 turnover of cases, and Propofol should not be staying
17 out that long.

18 Q The next handwritten note is she failed to
19 recognize the Propofol was not infusing but kept
20 assessing the patient to see how sleepy they were. Do
21 you see that?

22 A Yes.

23 Q Did that happen?

24 A I think from my recollection this is -- So

Page 357

1 the Propofol syringe is primed into an IV tubing that
2 then gets connected to the patient; but there is a
3 portion where you clamp it, and I think for a brief
4 second I had it clamped still and realized that later.

5 But the way she explained it, it seems
6 like it went on for some time. But from what I
7 recall, it was a brief period.

8 Q Does this comment say anything about how
9 long the Propofol was not infusing?

10 A No. I don't think so.

11 Q Did Eva Fisher point it out to you, that
12 the Propofol was not running?

13 A I don't recall like whether I realized it
14 myself or if she prompted me. I don't recall.

15 Q So it might be true that she had to point
16 it out to you?

17 A It's possible.

18 Q Okay. The next sentence is: She also had
19 trouble working the stop cocks on the IV. It says:
20 She repetitively turned them the wrong way. Did you
21 do that?

22 A The ending of the tubing sometimes --
23 Actually the tubing sometimes gets covered up, and at
24 one point maybe I got disoriented that I was turning

Page 358

1 it a certain way; and I could I have done it. But
2 it's usually a quick just flipping of a switch.

3 And, repetitively, I don't know if I
4 would agree with her on that because once you know
5 that it's not infusing on the one direction, then
6 obviously you would turn it another direction to help
7 it infuse.

8 So I have worked with stop cocks
9 multiple times. This is in every equipment that we
10 operate in the ICU or even like in the OR. So I'm not
11 unfamiliar with stop cocks. It's just that one
12 direction that I turned it to. She took issue on
13 that.

14 Q Well, you are not sure, are you, whether
15 you did it more than once? Do you actually remember
16 it?

17 A No. I don't recall.

18 Q And it says here that the attending
19 anesthesiologist had to show her how to use the stop
20 cocks. Did that happen?

21 A No.

22 Q How do you know?

23 A I just can't imagine that I wouldn't know
24 how to use stop cocks. Maybe he pointed out that it's

Page 359

Page 361

1 going the wrong way, it's the other way, but not
2 necessarily that he had to teach me how to work it.
3 I've worked with stop cocks constantly.

4 Q So the anesthesiologist may have had to
5 tell you you were turning it the wrong way?

6 A Possibly.

7 Q If you could turn to page Rush 78 in
8 Exhibit 12, this is an evaluation from Sheila Warren
9 of your work on March 10th, 2014; is that right?

10 A Yes.

11 Q And there is several unsatisfactory
12 ratings in this evaluation; is that right?

13 A Yes.

14 Q And if you look at Exhibit 11 on Page 13,
15 you don't see any reference -- I don't see any
16 reference to this evaluation from Sheila Warren; is
17 that right?

18 A Yes.

19 Q So did you write a rebuttal about Sheila
20 Warren's evaluation have you?

21 A I don't think I did.

22 Q Why not?

23 A I think because I don't really recall what
24 happened; and I had gotten all of these, my whole set

Page 360

1 of evaluations when I was dismissed. So trying to go
2 back and recall some things that actually sometimes
3 some of the evaluations Dr. Kremer brings up to my
4 attention, that's how I can remember some of it and
5 make a rebuttal of it. But this one, I don't remember
6 him bringing this to me; and so I don't recall the
7 details of what happened that day.

8 And so I think because I have no or a
9 very vague memory, perhaps we decided not to address
10 it because I don't know how to address it. I don't
11 know remember anything from the case.

12 Q If you turn to page Rush 76 which is the
13 next evaluation in Exhibit 12 --

14 A Yes.

15 Q -- is this an evaluation of your work on
16 March 14, 2014 by Katie Colino?

17 A Yes.

18 Q This evaluation, does it rate you as
19 unsatisfactory in two different categories?

20 A Yes.

21 Q And then the handwriting, there is
22 comments that say: However, suction hooked directly
23 up to wall?

24 A Yes.

1 Q Not to suction canister?

2 A Yes.

3 Q Did not recognize until student left for
4 something?

5 A For the day.

6 Q For the day.

7 And then there is a picture?

8 A Yes.

9 Q Did that happen?

10 A No, because if you probably looked up the
11 time stamp on this picture, the cases have ended which
12 means we used this setup. If it was connected
13 improperly, I would have ruined the vacuum on this.
14 It doesn't show the rest of the --

15 I brought this up to Dr. Kremer, that
16 it doesn't show the remainder of this setup. It
17 doesn't show where the canister is; and, like I said,
18 it's at the end of the day. Housekeeping might have
19 stripped off some of the equipment. So it's not
20 showing the full picture.

21 And, like I said, if we had used this
22 equipment in suctioning secretions, I would have
23 ruined the vacuum system if this was directly
24 connected to the patient.

Page 362

1 Q Do you know if you used the vacuum system
2 that day?

3 A I did because when we intubate patients
4 and we extubate, we have to clean up the secretions;
5 and sometimes if there is blood in here or even
6 irrigation, we have to clean this up with liquid which
7 will definitely reach the vacuum system and ruin it if
8 I connected it directly.

9 So I know that there has to be a
10 canister here to contain the secretions or irrigation
11 or blood, and that connects to the vacuum system. So
12 it shouldn't be a direct connection.

13 And, like I said, if you look at the
14 time stamp on this picture which they never really
15 showed me and, as she mentioned in her evaluation,
16 it's at the end of the day.

17 Q What are you talking about with the time
18 stamp on the picture? Do you see a time stamp?

19 A There isn't. That's what I'm saying.

20 Q So how do you know when it was taken
21 because you're saying it was taken later. How do you
22 know that?

23 A She says in here that suction canister,
24 did not recognize until after student left for the

Page 363

Page 365

1 day.
 2 Q How can you tell that says for the day?
 3 It says for --
 4 A Well, I think --
 5 Q Well, let me ask you. You don't actually
 6 know when this picture was taken; right?
 7 A No.
 8 Q So are you saying that Katie Colino made
 9 that up, that the suction was hooked up to the wall?
 10 A Well, it certainly doesn't show the whole
 11 picture.
 12 Q That's not really what I'm asking you.
 13 You're looking at the picture.
 14 MS. SIEGEL: Can you repeat the question,
 15 please?
 16 MR. LAND: I can ask it again.
 17 Q Are you saying that Katie Colino was
 18 making it up in her evaluation that she wrote down,
 19 that the suction was hooked up directly to the wall,
 20 not to the suction canister?
 21 A I didn't know what her intentions were,
 22 but it certainly wasn't clear what she is trying to
 23 point out here.
 24 Q Let's turn to Rush -- Well, let me ask you

Page 364

1 one other question. This evaluation from Katie Colino
 2 is also not included in your rebuttal document which
 3 is Exhibit 11, is it?
 4 A Yes.
 5 Q It's not in there; right?
 6 A No. It's not.
 7 Q Do you know why?
 8 A I think I discussed this with Dr. Kremer,
 9 and they didn't give me an answer as to why this is a
 10 partial picture which doesn't really show that this is
 11 hooked up to the suction directly for patient use.
 12 So I had asked Dr. Kremer if there was
 13 another set of pictures that could be connected to
 14 this that maybe we're missing so we could establish
 15 that I did incorrectly set up this suction.
 16 Q So because you had a conversation with
 17 Dr. Kremer you didn't include any rebuttal in your
 18 rebuttal document about this case?
 19 A Yeah. I think we were waiting for his
 20 response on maybe there is more pictures that weren't
 21 included; and I guess we had missed it at some point,
 22 like go back and do a rebuttal on this.
 23 Q Okay. Could you turn to Rush 74 in
 24 Exhibit 12. This is an evaluation of you by Mary

1 Rodzik, a case on March 20, 2014; is that right?
 2 A Yes.
 3 Q Does this contain several unsatisfactory
 4 ratings of your work?
 5 A Yes.
 6 Q In the handwritten comments there is a
 7 section that talks about preoperative assessments are
 8 okay; but she is still not asking all important
 9 questions, for example, when --
 10 Do you see what I'm talking about?
 11 A Yes.
 12 Q When was --
 13 What is the next word?
 14 A Coumadin stopped.
 15 Q What's the next?
 16 A When aspirin stopped, ASA stopped.
 17 Q What's the next one?
 18 A Activity to -- I can't read it, to enter,
 19 et cetera.
 20 Q Was this an accurate assessment of your
 21 work that day, that you didn't ask those questions?
 22 A From my recollection, I think I was going
 23 through like several questions; and I wasn't sure if
 24 she was in a hurry or if I was taking too long for her

Page 366

1 that she had cut me off and she then started asking
 2 these questions. So I didn't ask them because she had
 3 jumped in from what I recall.
 4 Q Later in her description by the word date
 5 that's on the form it says, I asked a lot of questions
 6 about --
 7 What comes after that?
 8 A Laryngospasm maybe or laryngoscope that is
 9 VAE which is -- I think that's embolism. Cardiac
 10 reflex, et cetera. She was able to answer them
 11 partially but not completely. This should all come
 12 second nature to her by now. You learn about this at
 13 the beginning of the program.
 14 Q So did she ask you about those questions
 15 on that day. Do you remember that?
 16 A I don't remember how extensive my answer
 17 was, but I imagine that I answered her questions; but
 18 I'm not exactly sure what more she was looking for.
 19 Q Do you know if those are issues or
 20 subjects that you would have learned about at the
 21 beginning of the program?
 22 A Yes.
 23 Q They were?
 24 A Yes.

Page 367

Page 369

1 Q Would you turn to the next evaluation.
 2 It's Rush 73.
 3 A Yes.
 4 Q Is this an evaluation of your work on
 5 March 24, 2014?
 6 A Uh-huh, yes.
 7 Q By who, Kathleen Oskvarek?
 8 A Oskvarek.
 9 Q Did she rate your performance as
 10 unsatisfactory in three different categories?
 11 A Yes.
 12 Q Can you read the handwritten comments
 13 there at the bottom?
 14 A Student has a difficult time performing
 15 basic functions under stress. She does not ask for
 16 clarification when she does not understand something I
 17 say. Maricel preop'd a second patient while I brought
 18 first patient to the unit. She waited until we
 19 brought the second patient in the room to tell me that
 20 she needs had a GlideScope but didn't call for one.
 21 Student has not given me an evaluation
 22 form the last three times we have worked together.
 23 Q Was that accurate?
 24 A I don't know if it's entirely accurate.

Page 368

1 Q Some of it is accurate?
 2 A Some of it.
 3 Q Is it accurate that you needed a
 4 GlideScope but didn't call for one?
 5 A We talked about it; and I think I had
 6 called for it when we got to the room, and it arrived
 7 there even before the case started. So it was really
 8 a non-event.
 9 Q Is there some idea that it's better to
 10 call for one before you get to the room?
 11 A Yes.
 12 Q Is it true that you had not given Miss
 13 Oskvarek an evaluation form the last three times she
 14 had worked with you?
 15 A I don't recall like the times that I was
 16 with her, so it's possible; but they can also get that
 17 themselves as I have seen other CRNAs fill them out.
 18 They don't have to rely on me to give it to them.
 19 Q Mike Kremer, hadn't he directed you to get
 20 evaluations from CRNAs for every case you had at this
 21 point?
 22 A Yes.
 23 Q Were you avoiding doing that?
 24 A At times I didn't have the eval on me; and

1 my understanding was if they really wanted to fill out
 2 one, it is there for them to get. Like some of the
 3 CRNAs filled it out without me giving it to them.
 4 Some of the CRNAs I have given evals they didn't
 5 return it.
 6 So I have given like three evals to Amy
 7 one time, but not one of them came back. This is when
 8 I came back from my leave of absence.
 9 Q What I asked though was: Were you
 10 avoiding giving evaluations to CRNAs so they would not
 11 evaluate your work after you came back in 2014?
 12 A Well, there are certain CRNAs I was not
 13 comfortable giving an evaluation to; but I understand
 14 it does not prevent them from evaluating me. So it's
 15 not entirely up to me to give it to them. Like in her
 16 case she sought it out; and she wanted to evaluate me,
 17 so she'll write it.
 18 Q Did you want to avoid giving one to
 19 Jillian Klunk?
 20 A No.
 21 (Marcial Deposition Exhibit No. 20
 22 was marked for identification.)
 23 Q You've been handed what's been marked
 24 Marcial Deposition Exhibit Number 20. Do you

Page 370

1 recognize this series of emails?
 2 A Yes.
 3 Q Is this an email that you sent to Marquis
 4 Foreman on February 9, 2014?
 5 A Yes.
 6 Q I'm sorry?
 7 A Yes.
 8 Q In the fifth paragraph of this email, do
 9 you write: Still because it wasn't a stellar day, I
 10 did not wish to give Jillian an evaluation form?
 11 A Yes.
 12 Q And that refers to Jillian Klunk?
 13 A Yes.
 14 Q After that you wrote: However, I knew
 15 that if I did not, that Dr. Kremer would contact
 16 Jillian directly to request one and that would make it
 17 look even worse for me; is that right?
 18 A Yes.
 19 Q So is that an example that you had
 20 previously avoided getting evaluations and wanted to
 21 that day?
 22 A I'm sorry. What was your question again?
 23 Q Is this an example of a day where you
 24 wanted to avoid having the CRNA evaluate you?

Page 371

Page 373

1 A It's possible.
 2 Q Isn't that what that's saying?
 3 A Yes.
 4 Q Isn't it referencing that Dr. Kremer had
 5 previously reprimanded you for not getting an
 6 evaluation form?
 7 A He had reminded me, yes.
 8 Q Didn't you use the word reprimanded me?
 9 A Yes.
 10 Q Can you turn back to be Exhibit 12 and
 11 turn to page Rush 70?
 12 A Okay.
 13 Q Is this an evaluation form for you
 14 completed by Dr. Judy Wiley for a case you worked on
 15 on March 25, 2014?
 16 A March 25, yes.
 17 Q And is there a reference under patient
 18 safety under I B and C to below level expected and
 19 unsatisfactory ratings?
 20 A Yes.
 21 Q Is this statement in paragraph B correct,
 22 that the label had fallen off and you injected with an
 23 unlabeled syringe?
 24 A Yes. I didn't recognize that it had

Page 372

1 fallen off, but everything else was labeled in that
 2 bundle of syringes that I had. Usually like we have
 3 maybe four or five syringes, and I think that was the
 4 only one that the label had fallen off.
 5 Q So the label had fallen off and the
 6 syringe and you still used it to inject the patient;
 7 right?
 8 A Yes.
 9 Q And Dr. Wiley was saying that you
 10 shouldn't do that; right?
 11 A After the fact she noticed that it wasn't
 12 labeled, and I explained to her it must have fallen
 13 off. But I am sure that it was Lidocaine because the
 14 other set that I usually draw like I said were all
 15 labeled, and I couldn't have given anything else
 16 except the Lidocaine.
 17 Q Can you turn to page Rush 68. Is Rush 68
 18 and 69 an evaluation of your work by Mary Rodzik on a
 19 case you worked on on April 1st, 2014?
 20 A Yes.
 21 Q This evaluation contained quite a number
 22 of unsatisfactory ratings; right?
 23 A Yes.
 24 Q Can you turn to the second page?

1 A Okay.
 2 Q What looks like sort of the second
 3 paragraph, it starts with I asked what?
 4 A I asked what the dose and route of
 5 Methergine was, and she didn't know the dose but then
 6 told me you would give it IV. Wrong, unacceptable.
 7 Q Is that accurate? Did that happen?
 8 A I did give her a wrong answer, but it
 9 wasn't a drug that we were -- She was quizzing me.
 10 Basically it wasn't a drug we were going to use.
 11 Q Can you read the next sentence?
 12 A Then asked the dose and route of other
 13 meds that you might use instead of Methergine. She
 14 told me Pitocin correct but could not something a dose
 15 or route, and she could not think of any more.
 16 Q Was that accurate?
 17 A I don't recall. It possibly could be.
 18 Q Okay. What does it say next?
 19 A I asked her about Hemabate, and she said
 20 she never learned about it. Huge lie, unacceptable.
 21 Q Let me ask you. Did she ask you about
 22 Hemabate?
 23 A She asked me about a drug that I think to
 24 the best of my recollection -- What is the drug that

Page 374

1 you use in OB to help decrease bleeding I think in
 2 terms of if we were doing D&C or addressing uterine
 3 fibroids? She didn't ask me -- She didn't say
 4 Hemabate. She asked me, What is the drug that you use
 5 for that purpose? And she said, You should remember
 6 this. You guys just went through this week.
 7 So at this point I was overlapping with
 8 the junior class, and so she thought that I had just
 9 gone to the OB class that week. And so she said, It
 10 starts with the letter H; and I asked her from what I
 11 recall, Do you know the category of drug that it is
 12 because in my head I was thinking of prostaglandin
 13 inhibitor which is what Hemabate is. But our lecture
 14 doesn't say Hemabate. It says prostaglandin
 15 inhibitor.
 16 So this was not in our lecture. And
 17 that's why she said it's a huge lie that I did not
 18 know about Hemabate; but she didn't ask me whether,
 19 you know, we had it in lecture recently because we did
 20 not have it in our lecture. It wasn't in our Power
 21 Point.
 22 I went back and looked for Hemabate in
 23 our Power Point in like the OB text; and what we have
 24 is prostaglandin inhibitor, not Hemabate. And then

Page 375

1 when I asked the juniors, they said, Yeah, we just
2 talked about this week, and they had it in their Power
3 Point, and they also have like a cheat sheet which is
4 a grid of different drugs, and Hemabate was there.

5 Q Are you saying you had never learned about
6 Hemabate at all?

7 A Not the drug name, but the category that
8 it belonged to.

9 Q So you are saying that you never learned
10 about Hemabate?

11 A I learned about it later but not at that
12 time.

13 Q You're saying that when you were a junior
14 in the same course you didn't have that?

15 A No. It wasn't in our lecture.

16 Q Can you read the next paragraph of notes
17 there?

18 A Sure. During one of our cases, our
19 patient's heart rate increased and the tidal volume
20 decreased. So I deepened anesthetic and hand
21 ventilated the patient for a while deepened.

22 The something had LMA. I asked if she
23 knew why; and she said because the LMA was dislodged,
24 not true. So asked what else could be concerned

Page 376

1 about. She could not answer.

2 I asked if she ever considered a
3 laryngospasm. Maybe patient was light, increased
4 heart rate and was on the brink of spasm, decreased
5 tidal volume, and she looked at me with a blank face.

6 Q Did you tell her that you thought that the
7 LMA might be dislodged?

8 A I think I recall having that answer.

9 Q And did she ask you what else it could be
10 and what else she could be concerned about?

11 A She might have. I mean I was asked
12 several things in that case.

13 Q Do you remember?

14 A I don't remember.

15 Q It says that I asked her if she ever
16 considered --

17 What's that next word?

18 A Laryngospasm, but I think that it got cut
19 off.

20 Q Did she ask you that?

21 A She might have. I just don't recall the
22 details.

23 Q Do you know if you looked at her with a
24 blank face after she asked you that?

Page 377

1 A I'm not sure. I don't remember. I know
2 that I was getting asked a lot of questions; but I
3 don't recall that, you know, part.

4 Q The next line says: LMA laryngospasm are
5 basic concept of anesthesia and she still not grasping
6 them. Is it true that LMA and laryngospasm are basic
7 concepts of anesthesia?

8 A Yes.

9 Q She then says: The meds I asked about
10 were in more advanced anesthesia classes; but since
11 she is finished with didactic, all questions are fair,
12 so she should be able to answer all questions. Do you
13 think that was accurate?

14 A That I should be able to answer all
15 questions without fail?

16 Q About the meds she asked you about from an
17 advanced anesthesia classes.

18 A I'm still a student. There is
19 opportunities or situations that I don't remember
20 things. And every year they update the lectures, so
21 there is certainly some things that I don't recall.
22 And I took didactics a year before.

23 With the leave of absence and not being
24 exposed to cases, there certainly are things that I

Page 378

1 had forgotten from when I last took courses back in I
2 think it was May of 2013. Yes. May of 2013 was
3 probably the last time we took courses.

4 Q So this was in April of 2014; right?

5 A Yes.

6 Q So it was several months after you've been
7 back in the OR; is that right?

8 A Yes.

9 Q And are you saying that they couldn't hold
10 you accountable for knowing about drugs that you
11 learned about during the didactic program?

12 A No. I'm just saying that there are times
13 that I would forget certain drugs, especially those
14 that I'm not familiar or not exposed to a lot.

15 Q Were those drugs that were going to
16 pertain to this case or these cases that you were
17 administering this day?

18 A No. She was just quizzing me on those
19 drugs. We weren't actually using them for the actual
20 case. She was just bringing up questions, and none of
21 these drugs were used for the case from my
22 recollection.

23 Q Could that recollection be wrong?

24 A I don't remember drawing anything else

Page 379

1 aside from the basic anesthesia induction drugs, so
2 these are just -- She was just quizzing me.

3 Q She wrote at the bottom here: More
4 importantly, she could have caused serious damage by
5 giving what is that, Methergine --

6 A Methergine IV.

7 Q Weren't you giving Methergine that day?

8 A No.

9 Q No?

10 A No. We didn't give Methergine that day?

11 Q Was it drawn up?

12 A No, because it's given when the patient is
13 bleeding to stop their bleeding or if their uterus is
14 spasming, you give that. It was a quick D&C, so there
15 was no risk of bleeding happening at that time. It
16 was like maybe a half hour procedure, from what I
17 recall.

18 Q Is it possible your recollection is not
19 right about that issue?

20 A I just remember never drawing it up. I am
21 very sure that we didn't use this drug during that
22 case, and I've never used Methergine in any of the
23 cases that I've been in.

24 Q You've never drawn up Methergine?

Page 380

1 A No.

2 Q If you turn to Rush 136, it's an
3 evaluation from Jim Miller dated May 21, 2014 of you;
4 is that right?

5 A Yes.

6 MS. SIEGEL: 136?

7 THE WITNESS: 136.

8 MR. LAND: Q That's an evaluation of your work
9 on May 21, 2014 by Jim Miller?

10 A Yes.

11 Q Jim Miller rated you as unsatisfactory in
12 one category?

13 A Yes.

14 Q Is Jim Miller a fair evaluator of you
15 generally speaking?

16 A At the beginning, yes, but later on, no;
17 and I remember when he started turning --

18 Q You do?

19 A -- unfair.

20 Q What do you remember?

21 A Dr. Kremer approached him at the beginning
22 of my case which he is apt to do with some of the
23 CRNAs that have worked with me. And after that, Jim,
24 I usually give him evaluations; but this time I'm not

Page 381

1 sure if I didn't have one or if I forgot to give him
2 one, but the next day he asked me for one which struck
3 me as a little odd which normally he doesn't ask for
4 one.

5 And this morning I remember, I recall
6 that Dr. Kremer did approach him; and I feel that that
7 had to influence him on what how he ranked me.

8 Q Based on what, just the fact that you saw
9 him talk to him?

10 A That and the way he interpreted this
11 negative evaluation and what happened actually
12 happened.

13 Q The way who interpreted this negative
14 evaluation?

15 A So he writes that --

16 Q Who interpreted it?

17 A Jim.

18 Q He wrote this; right?

19 A Yes.

20 Q So didn't he write: Clinically good day,
21 two intubations, intra op management done well,
22 independently with little help; right?

23 A Yes.

24 Q Do you agree with that?

Page 382

1 A I do.

2 Q Okay. Then it says: Wasn't able to
3 identify importance of blood pressure. What's that --

4 A Control with induction on something
5 cerebral aneurysm, maybe control with intervention. I
6 think this is like ruptured cerebral aneurysm, so that
7 part I dispute.

8 Q Are you saying it's not true?

9 A I'm saying that I was prepared to address
10 or I was prepared to participate in like this
11 particular procedure; and I know the question that he
12 asked me that he came to this conclusion because I
13 just remember a lot from that.

14 This was an add-on case, and we were
15 told about the procedure or the case right in the OR,
16 not the OR but the interventional suite. So the OR
17 nurse told us, there is a ruptured cerebral aneurysm
18 case that's coming up. It's an add-on. That's all I
19 know about the patient.

20 So then he and I went to the prep room
21 or the local to start preparing for this case; and
22 that's when he started asking me, What are the
23 anesthetic consideration for patients who have a
24 ruptured cerebral aneurysm. And of course in my ICU

Page 383

1 experience we go through an algorithm of A, B, C which
2 is airway, breathing, circulation.

3 So my only information on this patient
4 is that it's a ruptured aneurysm which means your
5 priority is securing their airway. So that's my first
6 answer to him.

7 And he said what else? Well, you have
8 to establish a stable -- you have to make sure that
9 they're ventilating fine because if the aneurysm is
10 ruptured, you could potentially suppress the
11 respiratory functions where it could potentially
12 affect the brain's respiratory center. And he said,
13 What else? Well, circulation which means you have to
14 control the blood pressure to control the bleeding.
15 Okay. So that was my third answer, and I think that's
16 what he wanted to hear first of all, not the other two
17 that I answered.

18 And so that's the only thing I recall
19 that made me think that he thinks I didn't know the
20 implications of anesthesia to a ruptured cerebral
21 aneurysm when, in fact, I did have a whole Neuropack
22 is what they call it which contains two
23 antihypertensive drips, three emergency
24 anti-hypertensive medications; and he saw me have all

Page 384

1 of those, that setup and the setup for the airway
2 ready before this case was started.

3 And so I just don't understand why he
4 thought I didn't know the implications of anesthesia
5 for cerebral aneurysm.

6 Q Did he talk to you about their evaluation
7 at all?

8 A No.

9 Q Did you ever talk to him about it?

10 A No. I didn't see it until I was
11 dismissed.

12 Q What about the next evaluation in Exhibit
13 12, Rush 135 --

14 A Yes.

15 Q -- evaluation by Jim Miller from -- It's
16 dated May 27, 2014 at the bottom.

17 A Yes.

18 Q Do you remember this evaluation?

19 A I saw it like I said when I collected all
20 of my evaluations when I was dismissed but not at the
21 time that he filled it out.

22 Q Is this an accurate description of your
23 work that day?

24 A Let me just read the bottom. Pediatric

Page 385

1 add-on case, struggled to know drug dosage. Difficult
2 time setting up for case in short period of time. Was
3 told to give 5-milligrams Hydralazine, gave 10. Don't
4 she think she knew the dose and concentration or she
5 just didn't listen to me.

6 I think there was a lot of I guess
7 misunderstanding that day. I have not had a pediatric
8 case since I think 2013, and so certainly it's a
9 little -- I'm a little slow with setting up for peds
10 cases. So a short period of time, I would believe
11 him, that I couldn't like set up what I needed for a
12 pediatric cases as quickly as he wanted me to.

13 And in terms of the Hydralazine, he's a
14 little soft spoken; and with a mask, I had my back
15 turned against him as I'm attending to the patient.
16 So I think I just heard him say give Hydralazine but
17 not the dose that he wanted me to give. And since
18 this is what I'm accustomed to giving to start out at
19 10 milligrams, that's what I gave.

20 And then I told him, I think you said
21 10 milligrams or I think you said Hydralazine and I
22 assumed you wanted 10-milligrams. So that's what I
23 recall from that day.

24 Q So you gave a higher dose to this

Page 386

1 pediatric patient?

2 A No. This is actually another case. It's
3 I think for the single spine procedure.

4 Q I thought you were just explaining you
5 were unfamiliar with pediatric cases?

6 A That's this one section here, pediatric
7 add-on case; but these are two cases, and I think he's
8 referring to Hydralazine for the second case which is
9 the single spine adult case.

10 Q So is he right that he told you to give 5
11 milligrams but you may not have heard him?

12 A I may not have heard him, and that's
13 usually the amount that we start at with Hydralazine.
14 It's a 20-milligram half vial. We give half usually
15 and see what their response is.

16 Q He also writes here next to reliable
17 anesthesia team member, still needs to be prompted,
18 instructed throughout. Did that happen that day?

19 A It could have, but I don't recall since I
20 think I was paired with him after I was in ECT which
21 is a whole different procedure. So I don't recall
22 like if it was a last minute pairing like the case was
23 also added last minute, so I don't recall a whole lot
24 about that day.

Page 387

Page 389

1 Q Could you turn to page Rush 55. It's an
2 evaluation by Katie Colino?
3 A Okay.
4 Q Is this an evaluation of you?
5 MS. SIEGEL: Is this 55?
6 THE WITNESS: 55.
7 MR. LAND: Q Is this an evaluation from Katie
8 Colino of your case on May 29, 2014?
9 A Yes.
10 Q She rated you unsatisfactory in many
11 categories; is that right?
12 A Yes.
13 Q Was this the last case you worked on in a
14 clinical setting at Rush?
15 A Yes.
16 Q There is a reference in the additional
17 comments to a CO2 monitor, and it says it was not
18 turned on?
19 A At the start of the case before the --
20 Actually it's not at the start. I mean we were I
21 think prepping for our cases.
22 Q Was it true that it wasn't turned on?
23 A Yes.
24 Q What does it say after that in the

1 But she did not tell me that another
2 student had already prepared for this patient. And
3 basically she took me from one case that I wasn't
4 finished yet and added me to this case. But other
5 student already saw and prepared for this patient.
6 Q Can you turn to the second page, the
7 handwritten notes. Start with what's after the
8 parentheses after the second page.
9 A Done by other anesthesia provider.
10 Q So after that it says: Patient pale,
11 patchy hair.
12 A Patient pale, patchy hair. On nasal
13 canula with oxygen sats in the low nineties.
14 Q Does that indicate anything to you about
15 the patient's condition?
16 A Yes.
17 Q What does that indicate to you?
18 A That he's a frail, sick patient.
19 Q Can you reads what follows there?
20 A On nasal canula with O2 sats in low
21 nineties. Doses given by CRNA very low and verbalized
22 to Maricel. She should be able to pick up on clinical
23 situation even if didn't quickly scan anesthetic
24 record or looked at patient and realized important to

Page 388

Page 390

1 handwritten next?
2 A I was instructed to draw up Fentanyl.
3 Student drew up, something drew up Versed and
4 Fentanyl, not detrimental but demonstrates difficulty
5 following instructions. Instructions to some, some
6 kilogram patient with an esophageal cancer. I don't
7 know what this is saying. 24 percent EF. Very
8 explicitly told what meds to give. Light sedation was
9 requested.
10 Q Doesn't it say required?
11 A Was required. Patient proceeded to --
12 Wait, something proceeded to attempt to go up on
13 Propofol drip. Maricel states was rushed and didn't
14 have time.
15 Q Hold on. Before you turn, does this say
16 that you were instructed to draw up Fentanyl but you
17 drew up Fentanyl and another drug?
18 A Yes.
19 Q And did that happen?
20 A Yes. She didn't tell me that there were
21 actually other drugs drawn; and so our practice with
22 this particular case is that we draw up Fentanyl,
23 Versed and Propofol and I think Lidocaine as well. So
24 I was prepping for a typical case.

1 look at record.
2 Q Do you remember if this patient appeared
3 to be particularly sick?
4 A Yes, at the actual procedure. That's the
5 first time I saw him.
6 Q When you were there, you noticed that?
7 A Yes.
8 Q In a way is it accurate as she has
9 described here, that would affect your view of how to
10 treat the patient?
11 A Yes.
12 Q Go on with what she wrote here.
13 A To look at record. Was told to give 25
14 mics Fentanyl. Maricel put syringe to patient. Was
15 noted by CRNA that 50 mics was missing. Realized
16 that she grabbed Fentanyl syringe that she used from
17 prior patient.
18 Q So that happened; right?
19 A Yes. We both caught it before it was
20 given to the patient. So nothing was given to the
21 patient yet.
22 Q And that's what it says after that; right?
23 A No Fentanyl from that syringe was
24 administered because CRNA witnessed event.

Page 391

1 Q Is that true?

2 A Well, we both caught it. I said, This
3 looks not full, and so I didn't give it because then
4 we both realized I still had my Fentanyl from the case
5 that I had just finished that I'm supposed to -- I'm
6 supposed to waste that with another practitioner or
7 another student to make sure that we account for the
8 remainder of any narcotic.

9 That's how we usually end our cases.
10 We dump our old unused medications, especially
11 narcotics and witness that with another person.

12 So because I was hurried, I didn't get
13 a chance to do that, and that's why there were two
14 Fentanyl syringes in my pocket which we both caught.

15 Q Eventually with this patient did you try
16 to administer more of a drug than Katie Colino thought
17 you should have?

18 A No. From what I recall, I recall -- So
19 she told me that this patient had a cardiac condition,
20 that EF was low; so we should be very careful about
21 sedating him too much.

22 And unfortunately I think from what I
23 remember, the patient was squirming around with an
24 endoscope in his mouth; and I overheard the comments

Page 392

1 of the gastroenterologist that he has a lot of
2 esophageal erosions. And so my concern was that we
3 could potentially, he could potentially lacerate the
4 esophagus with the patient moving around.

5 And so I checked to see, I checked to
6 make sure that we were giving the right amount of
7 Propofol; or I wanted to check what was running, and
8 she stopped me and said, Don't touch it. He's fine
9 where he's at.

10 So I didn't increase the Propofol.
11 I just tried to turn the infusion pump to check how
12 much I was giving the patient. But I didn't even
13 touch the button to raise the dose of Propofol that we
14 were giving, and that wasn't my intention. I just
15 wanted to make sure that I was checking the amount I
16 was giving him.

17 Q Were you thinking that the Propofol dose
18 was inadequate and that it should be increased?

19 A I was trying to check how much I was
20 giving, and I was also thinking of other adjunct or
21 other medications that we could give that would not
22 affect the patient's ejection fraction or would not
23 depress the patient's cardiac function.

24 Q I asked a really straight forward

Page 393

1 question, and you're talking about these other things.
2 I asked if you thought that the Propofol dose was
3 inadequate for this patient and were you considering
4 increasing it?

5 MS. SIEGEL: I'm going to object. The witness
6 testified to what her thought process was in response
7 to your question.

8 MR. LAND: She talked about a lot of things
9 other than what to do with Propofol.

10 Q What I want to know is if you thought the
11 Propofol dose was inadequate and if you were
12 considering increasing it?

13 A I didn't think it then. I wanted to check
14 to make sure I put in the correct amount that she told
15 me, and I didn't think then that's what I was going to
16 use.

17 Q So you were checking to see if you put in
18 what she told you to?

19 A Yes.

20 MR. LAND: Would you mark this as Exhibit 21.
21 (Marcial Deposition Exhibit No. 21
22 was marked for identification.)

23 Q Do you recognize Exhibit Number 21?

24 A Yes.

Page 394

1 Q Did you write this document?

2 A Yes.

3 Q Did you write it on May 29, 2014?

4 A That's what it says here.

5 Q Wasn't this the same day as the evaluation
6 with Katie Colino?

7 A Yes.

8 Q This is the day you were sent out of the
9 OR?

10 A Yes.

11 Q This is referring to the evaluation we
12 were just discussing?

13 A Yes.

14 Q If you look in the fourth paragraph, do
15 you see that?

16 A Yes.

17 Q Despite the Fentanyl re-dose, the patient
18 continued to move. I looked at the Propofol drip and
19 confirmed that the rate was still 30 mics?

20 A Yes.

21 Q So you knew what it was; right?

22 A Yes.

23 Q At this time vital signs were stable in
24 the 130s over 80s and saturation was normal. Because

Page 395

1 the patient was moving, I felt that this Propofol dose
2 was inadequate and reached over to the pump to confirm
3 that it was indeed at 30 and also because I was
4 considering increasing the dosage to 40 mics; right?

5 A Yes.

6 Q Was that accurate?

7 A I guess that's what my thought process was
8 then.

9 Q It's different than what you were just
10 saying, isn't it?

11 A Yes. From my recollection if I had this,
12 then that's what I was thinking then.

13 Q So you were thinking about increasing the
14 dosage, not just checking to see if you had done it
15 correctly as Colino had told you; right?

16 A Yes.

17 Q That's when she told you not to increase
18 it?

19 A Yes.

20 Q Had she already told you it was a cardiac
21 patient?

22 A Yes.

23 40 mics is still a low dose for an
24 adult this size.

Page 396

1 Q Wasn't that the whole point of her concern
2 with you was that you were seeking to increase the
3 Propofol dosage on a cardiac patient which would cause
4 potential problems from her perspective?

5 A Yes, but I mean every practitioner has a
6 range that they feel is safe for somebody, especially
7 considering the ejection fraction here. So 40 is
8 still within range for somebody with that condition.

9 Q That's your opinion; right?

10 A Well, that's founded in textbooks, and
11 I've worked with ICU intensivists and some
12 anesthesiologists who would consider that this is
13 still acceptable; and especially it's short-term.
14 It's not like it's infusing for several hours. This
15 is just -- This is a 30-minute procedure.

16 Q So you still think now it would have been
17 okay to increase that dosage to 40 mics?

18 A Possibly.

19 Q So later in this document here, the last
20 paragraph on this page, it says: I relied that I
21 understand that, but I did not know anything about
22 this patient. So I'm confused?

23 A That's what she told me.

24 I did tell her that I didn't read this

Page 397

1 patient's history and am just going by, you know, the
2 patient's appearance and what she said.

3 You can't give a high dose to a cardiac
4 patient. I guess in my head I dispute that that
5 really was a high dose.

6 Q You wrote this rebuttal at the time of
7 this evaluation that Katie Colino gave you?

8 A Yes.

9 Q Isn't this the first one you wrote?

10 A I had written some before which I offered
11 to Dr. Kremer if he wanted to read it; but he said, I
12 am not interested.

13 Q When did you do that?

14 A In one of our meetings I told him that I
15 have rebuttals that are written. If you want them, I
16 can email them to you. So in one of our Friday
17 meetings, I had a prepared rebuttal; but he wasn't
18 interested in having them.

19 Q You said it was in one of your Friday
20 meetings that you said that to him?

21 A Yes.

22 Q Do you have any time period you can put
23 that in?

24 A Probably either May or like late March.

Page 398

1 I don't recall.

2 Q Late March you think?

3 A In one of our Friday -- because when I
4 came back from my LOA, we're supposed to meet every
5 Friday as soon as I returned from my LOA. It was one
6 of the learning plans that we had talked about, to
7 meet every Friday.

8 Q Was it only one time that you offered him
9 to share written rebuttals?

10 A I don't recall. I mentioned it. He
11 said -- He had asked me like, Do you have -- well, do
12 you have rebuttals for this evaluation? Like he would
13 present an evaluation to me; and I said, I do have
14 some prepared. Would you like to have them, and he
15 said no, like he wasn't interested.

16 Q Did you have weekly meetings with
17 Dr. Kremer after you returned in January of 2014?

18 A For the most part. There is times that I
19 would be dismissed like sometimes 7:00 o'clock or
20 8:00 o'clock from my cases, so then he would be gone
21 for the day; and certain times I would leave him a
22 note in his door that I stopped by, but he was already
23 gone for the day.

24 And then I think at one point either I

Page 399

1 text'd him or I emailed him saying, did you still want
2 to meet or can you meet today, and he told me, If I'm
3 not there, then just ask Evelyn for your records to
4 review.

5 So we agreed to meet every Friday at
6 the end of the week, but it wasn't always feasible
7 based on my schedule or his schedule.

8 Q Did you have some meetings with him on
9 Fridays?

10 A Yes.

11 Q Did you review evaluations that he had
12 received during those meetings?

13 A Some of them.

14 Q Were some of them the ones we have been
15 looking at today?

16 A Yes.

17 Q So you saw on unsatisfactory ratings from
18 that time period --

19 A Yes.

20 Q -- some of them?

21 But you didn't give, Dr. Kremer any
22 written rebuttals until this Exhibit 21?

23 A Yeah. I was verbally explaining to him.

24 My rebuttal is basically verbal when I meet him for my

Page 401

1 Keehn, Leah Forester, Eva Fisher, Jill Wimberly, Mary
2 Rodzik. I think that's what I recall.

3 Q So you received unsatisfactory ratings
4 from many more CRNAs than those; right?

5 A Yes.

6 Q Do you think it's accurate that as many as
7 16 different CRNAs gave you unsatisfactory ratings?

8 A I guess I don't have the record for me to
9 agree with that or confirm that.

10 Q It was a large cross section of them
11 though; right?

12 A Yes.

13 MR. LAND: Do you want to take a quick break?

14 (Whereupon a brief recess was had,
15 after which the deposition of
16 Ms. Marcial continued as
17 follows:)

18 Q I'm going to hand you what's been marked
19 as Maricel Deposition Exhibit Number 1 which is a copy
20 of the Second Amended Complaint. We looked at this
21 during your first session. If you can turn to
22 Page 33, it has a count Tortious Interference With
23 Contract Against Defendants Kremer, Narbone, and
24 Wimberly. Do you see that?

Page 400

1 weekly meetings.

2 Q In this Exhibit 21 on the second page, on
3 the second to the last paragraph, there is a sentence
4 that begins on the right-hand side at the top line,
5 I have done well in every sphere, and that does not
6 involve a particular group of Rush CRNAs?

7 A Yes.

8 Q What did you mean by that? What group of
9 Rush CRNAs are you talking about there?

10 A Well, like around this time I had already
11 talked to several people who have the same, had the
12 same experience as mine; and we had identified a core
13 group of CRNAs who we felt were not very fair with
14 their evaluations.

15 And I had mentioned it to Dr. Kreiner,
16 the psychiatrist, as well as Dr. Terreberry; and they
17 both had confirmed that those names were familiar,
18 that the other students have also experienced
19 difficulties with them. So that's what I was
20 referring to here.

21 Q Which other CRNAs, group of CRNAs are you
22 talking about?

23 A So in comparison with the other students,
24 that we have all had the same experience, Angela

Page 402

1 A Yes.

2 Q Do you understand that as being a cause of
3 action -- I won't ask you much about legal issues
4 here -- against the individual defendants in their
5 individually capacities as opposed to against Rush
6 itself?

7 MS. SIEGEL: Objection. It calls for a legal
8 conclusion.

9 A I imagine if they're representing Rush
10 that that's what I'm alleging here, that they are part
11 of the institution, and so they are representing --

12 MS. SIEGEL: Don't speculate.

13 MR. LAND: You just interrupted her in mid
14 answer which you really shouldn't do.

15 MS. SIEGEL: You shouldn't be calling for
16 speculation.

17 MR. LAND: Asking her if she is suing people in
18 their individual capacity? Seriously, Elaine, that's
19 an unprofessional interruption. It's beneath you.

20 Q Paragraph 149 indicates defendants Kremer,
21 Narbone, Wimberly willingly, intentionally, and
22 unjustifiably impeded plaintiff's progress within Rush
23 CRNA's program by continually issuing false and
24 misrepresentative evaluations with respect to

Page 403

1 plaintiff and by subjecting plaintiff to undo
2 harassment and discrimination.

3 Do you see that?

4 A Yes.

5 Q How many evaluations did Jill Wimberly
6 write of you that were false or misrepresented
7 anything?

8 A I know of two that was misrepresented.

9 Q One in June of 2013 and the other in
10 January of 2014?

11 A Yes.

12 Q Is that what you mean by continually
13 issuing false misrepresentative evaluations with
14 respect to Jill Wimberly?

15 A With respect to her, she had also
16 influenced Eva who had then influenced -- I don't know
17 who, but I know one person that, another student
18 witnessed Eva talking to about me in a disparaging
19 way. So she had influenced that person, and I don't
20 know from there where the message had been spread out
21 to.

22 Q So if Eva Fisher writes an evaluation, you
23 claim that that's Jill Wimberly issuing an evaluation?

24 A She was definitely influenced to issue me

Page 404

1 a false evaluation.

2 Q Based on what you testified to in your
3 first session; right? We talked a lot about the basis
4 for your belief that Jill Wimberly influenced Eva
5 Fisher. Do you remember that?

6 A I think I remember that part. I don't
7 recall the exact details.

8 Q Okay. Did Mike Kremer ever issue,
9 Dr. Kremer ever issue a false or misrepresentative
10 evaluation of you?

11 A He upheld the false evaluation even though
12 I implored him to check or investigate the validity of
13 these evaluation; and despite that, he maintained
14 giving credit to those false evaluations.

15 Q So he didn't actually issue one though;
16 right?

17 A No. He just supported it.

18 Q By not deleting it?

19 A By including it in my file of evaluations.

20 Q Is that part of his job to include CRNA
21 evaluations of SRNAs in their files?

22 A Yes, but he also needs to determine the
23 validity of them, if they're really worth, if they're
24 really credible and if it's really reflective of my

Page 405

1 performance.

2 Q What did Ray Narbone do to issue a false
3 or misrepresentative evaluation, if anything?

4 A Well, he had allowed me to be paired with
5 what I presented before as a problematic match with
6 Jill. I had brought that problem to him before, and
7 he had ignored that and intentionally texted me and
8 Jill that we're being paired. And then again sometime
9 in April I think he tried to pair me with her even
10 though he knows of the incompatible pair-ups that we
11 have.

12 Q So it wasn't until after the June 20
13 evaluation you received from Jill Wimberly that you
14 asked to not be paired with her; right?

15 A Yes.

16 Q And you worked with Jill once after that;
17 right?

18 A June, then January; and I was assigned to
19 her but didn't work with her, yes.

20 Q So you were assigned and worked with her
21 once?

22 A Yes.

23 Q After you asked to not be assigned to her;
24 right?

Page 406

1 A I was assigned three times, but I worked
2 with her just once out of those three.

3 Q So my question was: Did Ray Narbone ever
4 issue any evaluation of you?

5 A No.

6 Q So all he did was assign you to Jill
7 Wimberly after you asked not to be assigned. That's
8 all he did that you think that he did that's
9 problematic?

10 A Well, aside from that, he had made sure
11 that, you know, like I don't have, that I can't refuse
12 being sent to her. And then he came up one time and
13 talked to her that day of January 20 which is unusual
14 because we were in 7 Tower; and normally around that
15 time, he's busy coordinating cases in 5 Tower. So I
16 felt that there was that added, you know, pressure or
17 interaction that they had that made me feel like this
18 was very -- this is going to be a negative encounter.

19 Q So he assigned you to Jill once, and then
20 he talked to Jill that day in front of you. Do you
21 know what he said to her that day?

22 A Well, Friday I argued with him.

23 Q That's really not what I'm asking. Do you
24 know what he said to Jill that day that she evaluated

Page 407

1 that day on January 20, 2014?

2 A I don't. I don't know what he said.

3 Q So other than having a conversation with
4 her, you don't know what he said. In assigning you to
5 work with her that day, did he do anything that you
6 believed is issuing a misrepresentative evaluation or
7 subjecting you to harassment and discrimination?

8 A Well, the meeting we had in October was
9 definitely very harassing when he started calling me
10 names and just all of the disparaging remarks he right
11 off the bat told me even though Dr. Kremer had told me
12 that that meeting is supposed to be for me to be set
13 up for my return in January, not as a counseling at
14 all.

15 So in that meeting, he was definitely
16 more than harsh with me and reassured me that I will
17 be failed, and he assured me of different hurdles and
18 different difficulties that he guarantees will happen
19 when I return.

20 Q So his comments to you in one meeting, his
21 assignment to Jill Wimberly for one day and his
22 conversation with Jill Wimberly on that day that you
23 don't know what he said, is that the full extent of
24 anything he did that you think was harassing or

Page 408

1 discriminatory?

2 A We have had other encounters which I can't
3 recall right now; but I felt for sure that he had a
4 hand in how I was being treated, how the CRNAs'
5 behaviors have followed this pattern. Ever since my
6 event with Jill in June, things have just spiraled
7 down from one person who wasn't writing me up, and I
8 was doing so well before the June event for a whole
9 year and a half I think.

10 And then suddenly from that event
11 moving forward, I had the multiple negatives which as
12 hard as I tried to reason them with Dr. Kremer, he
13 didn't hear or investigate or help me in trying to
14 sort this out but instead just criticized me,
15 scrutinized me for anything that I had to say about
16 these evaluations without him investigating the
17 validity of them.

18 Q So I was asking about what Mr. Narbone
19 did, and I think all I heard you say in there was you
20 believed that he influenced other CRNAs in how they
21 treated you?

22 A I have a sense that he did because during
23 our meeting in October, he said that if I took a poll
24 among the CRNAs whether you should return, I guarantee

Page 409

1 you that they will all unanimously vote you out.

2 So --

3 Q Do you know if he actually took a poll?

4 MS. SIEGEL: She's still talking.

5 MR. LAND: I'm sorry.

6 A I don't know.

7 But all of the implications were that I
8 cannot control their behavior and I will not stop them
9 from how they're going to treat you, and I know that
10 they're not going to look at you the same way as when
11 you were a brand new person. So every mistake you
12 make will be looked at in the most harsh or
13 unfavorable way towards you.

14 MR. LAND: Q Well, he didn't actually say
15 that; right?

16 A He did say that in that meeting.

17 MS. SIEGEL: Argumentative.

18 Can we have the last question and
19 answer, please.

20 (Whereupon the requested portion
21 of the record was read.)

22 A He did say that.

23 MR. LAND: Q Are you saying that he told you
24 that every mistake you made would be viewed in the

Page 410

1 most harsh and unfavorable way towards you, those
2 words?

3 A I'm paraphrasing from what I recall from
4 that meeting, but he did indicate that if you made a
5 mistake it's not going to be looked at the same way.

6 Q Didn't you submit a written document --

7 A I did.

8 Q -- to Terreberry that tried to explain as
9 best as you could recall what Ray Narbone said to you
10 in that October 24, 2013 meeting?

11 A Yes.

12 Q So I don't think that anything that you
13 just said about what he said to you you would say he
14 said those words to you unless they're in that
15 document that you wrote for Terreberry; is that right?

16 A Not the exact words, but I'm paraphrasing
17 from that meeting what he said.

18 Q In Paragraph 151 on Page 34 of your
19 complaint --

20 A Yes.

21 Q -- it alleges with actual malice
22 defendants Kremer, Narbone and Wimberly by
23 intentionally and unjustifiably inducing plaintiff's
24 removal from the Rush CRNA program acted in their own

Page 411

1 self-interests outside the scope of their agency
2 relationship with Rush and contrary to the interests
3 of Rush. Do you see that?

4 A Yes.

5 Q Was it Jill Wimberly's job to evaluate you
6 as a CRNA --

7 A Yes.

8 Q -- when you worked with her?

9 A Yes.

10 Q Was it Dr. Kremer's job to evaluate your
11 progress in the SRNA program?

12 A Yes.

13 Q Was it his job to review the CRNA
14 evaluations of you?

15 A Yes.

16 Q Was it his job to work with Ray Narbone
17 about scheduling SRNAs and CRNAs?

18 A Yes.

19 Q Can you find Exhibit 3 which is the
20 interrogatory responses. I think it's over there.
21 Could you turn to Page 42.

22 A Okay.

23 Q Interrogatory Number 13 is near the
24 bottom, and it asks to state every fact supporting

Page 412

1 your contention that each of the following defendants
2 acted in their own "self interest" in relation to
3 plaintiff's removal from at the program as alleged in
4 Paragraphs 151 and 161 of the complaint. Do you see
5 that?

6 A Yes.

7 Q Can you tell us how Dr. Kremer acted in
8 his own self-interest? What was his self-interest in
9 the way he acted towards you?

10 MS. SIEGEL: Calls for a legal conclusion.

11 MR. LAND: Really?

12 MS. SIEGEL: Really.

13 MR. LAND: Q You don't know?

14 A Well, there are many things that he had
15 neglected to support me and did not like I said
16 validate or investigate the validity of some of the
17 evaluations but considered them as infallible. So I
18 think his self-interest there is he didn't want to the
19 go against the CRNA group and decided to just
20 basically discredit me.

21 So despite my explanations of why
22 certain evaluations are false and I told him, check it
23 with the anesthesia record to validate the accuracy of
24 these evaluations, he did not do that.

Page 413

1 Q And so because he believed the CRNAs and
2 didn't believe you, you think he acted in his
3 self-interest?

4 A He certainly put more value in their
5 evaluations as opposed to what I'm pointing to him,
6 for him to do in order to validate the accuracy of
7 those evaluations. He didn't do his due diligence to
8 verify whether those, you know, evaluations --
9 Considering other students have also filed similar
10 complaints, he did not do his due diligence to
11 investigate the validity of those evaluations and to
12 support me.

13 Q Is there anything besides that that he did
14 that you think shows that he acted in his own interest
15 and not in the interest of Rush?

16 MS. SIEGEL: Continues to ask for legal
17 conclusions.

18 A Every time we had met for like the end of
19 the week, he was always like demeaning and disparaging
20 me despite my best efforts, and I was pointing out to
21 the him that I do have positive evaluations, have
22 performed well in several instances; and he still goes
23 back to, you know, my negative evals no matter how
24 well I've proved them.

Page 414

1 So he does not listen to my
2 explanations but persists in, just persists in his own
3 beliefs. And so he did not perform his duty as the
4 advocate for the student but acted as an opponent
5 basically in opposition to me.

6 So that's how I saw him every single
7 time. It wasn't a supportive interaction. It was
8 always criticisms, scrutiny, and nothing to, you know,
9 support my point of view.

10 Q Did he offer you multiple opportunities to
11 try to improve?

12 A Because that's my right as a student
13 there. I'm entitled to support remediation in what he
14 thinks I think I need to work on.

15 But I can tell you that was given to me
16 begrudgingly because even when I said if you're going
17 to put me away for five months on leave of absence,
18 then you would have to consider that I should come
19 back with a fresh start. And he said, no, I don't
20 agree with that; and I had to fight for that.

21 I didn't ask for the five-month leave
22 of absence. I had no choice but to comply with him.

23 Q Other than how he handled your leave of
24 absence or believing the CRNAs' evaluations of you,

Page 415

1 was there anything he did that you think he was acting
2 in his self-interest?

3 A Yes.

4 MS. SIEGEL: Calling for a legal conclusion.

5 A Yes. So when I came back from sim lab or
6 for sim lab, he was standing in a very close distance
7 from me and was basically telling Sherwin Sampson, one
8 of the instructors that, you know, she thinks that
9 everybody is ganging up on her. So he's basically
10 disparaging me in front of another instructor as I'm
11 doing a simulation procedure.

12 Q Why do you think that's in his
13 self-interest?

14 A Because he was irritated that I was still
15 trying to come back when he and Narbone had told me,
16 you know, we don't want you to come back anymore
17 basically, like it's not advisable for you to come
18 back. He didn't want to give me that chance. So it
19 was too difficult for him I guess to support me in
20 going through with my program.

21 Q Is there anything else that he did that
22 acted in his self-interest?

23 A I think there were multiple things that I
24 can't remember off the top of my head right now.

Page 416

1 Q What about Ray Narbone? In Exhibit 3
2 under Interrogatory Number 13 under Ray Narbone you
3 say that he called you delusional to think that you
4 would complete the program stating that he did not
5 envision how you could be treated objectively upon
6 your return from the leave of absence. And while
7 ignoring your complaints about Jill Wimberly, Narbone
8 consistently paired you with Jill Wimberly.

9 Is there anything other than that that
10 you think that Ray Narbone did that acted in his own
11 interest?

12 A Well, that whole course -- I don't know if
13 you mentioned that whole discussion that we had in
14 October where he basically told me what he thought
15 about me.

16 Q Tell me how is that, what interest of his
17 would that be advancing?

18 A That he doesn't have to deal with a
19 student who is posing or questioning, you know, I
20 guess the evaluations of his CRNAs, that he has to
21 work harder to support me and basically go against his
22 CRNA staff, that he's somehow giving me some credence
23 over his CRNA staff is how I perceived it.

24 Q What was his personal interest in

Page 417

1 assigning Jill Wimberly to you in the OR?

2 A I can't say for sure what his intentions
3 were, but I've definitely heard of how he could be
4 vindictive coming from the mouth of his own CRNA, that
5 if a student questions him, then, you know, you are
6 asking for trouble.

7 That's when Amy Gawura warned one of
8 the questions like, I wouldn't question him while
9 you're getting assigned cases because you're just
10 asking for trouble.

11 Q What about Jill Wimberly, what
12 self-interest of hers do you claim she was pursuing in
13 evaluating you negatively?

14 A I'm not sure why she had to fabricate all
15 of those things. But just based on her other, her
16 previous interaction with Karen and how she also
17 treated the white student who was with Karen, she
18 showed her bias, her prejudice towards a certain group
19 of students and not so much, you know, certain types
20 of students.

21 So she was acting on her own, you know,
22 prejudices and I think her self-interest to be proven
23 that she is always right even though she is really
24 putting out false information or misrepresentations of

Page 418

1 my work.

2 Q So I believe you are limiting your
3 assertions against her to her evaluations of you and
4 comments she made to other CRNAs about your work; is
5 that right?

6 MS. SIEGEL: Mischaracterizes the witness's s
7 testimony.

8 A Well, I'm not sure what else, like what
9 her other intentions are; but definitely each
10 encounter has been -- Like the times that I was
11 assigned to her, there's always negative feedback.

12 When Ray dismissed me, when she had
13 taken over Leah's case, that led to feedback that was
14 negative by Leah, influenced by her. And, yeah, just
15 the interactions have not been supportive or positive
16 with her.

17 Q That's what I'm asking about. Other than
18 the times she evaluated you and other than your
19 allegations about what she said to other CRNAs about
20 your work, what else are you saying she did that you
21 think was wrong or a problem for you?

22 MS. SIEGEL: Calls for a legal conclusion.

23 MR. LAND: What's the legal conclusion? I
24 mean, Elaine, come on.

Page 419

1 MS. SIEGEL: You're asking this witness what
2 violated the law.

3 MR. LAND: No. I'm not. I didn't ask that.

4 MS. SIEGEL: It's a legal conclusion.

5 MR. LAND: Q I'm asking other than Jill
6 Wimberly evaluating your work in written evaluations
7 and interacting with you in the OR, in talking with
8 other CRNAs about your work as a CRNA, what else are
9 you saying that she did wrong or created a problem for
10 you?

11 A Even though she did the evaluations, they
12 were flagrantly false. A lot of them had --

13 Q What besides that, Maricel? That's what
14 I'm asking.

15 A That had led to Dr. Kremer basically
16 considering that as like grounds for failure. He said
17 two strikes and you are out. And considering that
18 evaluation that she basically provided all false
19 testimony or false information, so her action she knew
20 would lead to me being confronted or held back by, you
21 know, through Dr. Kremer's judgment.

22 And she knew that, you know, whatever
23 negative evaluations she put will catch his attention,
24 and she probably was hoping that I would get in

Page 420

1 trouble once Dr. Kremer sees what she's written there,
2 even though it's full of falsehoods.

3 Q So I have to ask again: Other than
4 writing the evaluations of you that you just talked
5 about and talking to other CRNAs about your work, do
6 you allege that Jill Wimberly did anything wrong or
7 anything else to create problems for you?

8 A Well, her behavior with me during our
9 interactions in our cases, like pushing me in the
10 chest, screaming in my ear as I'm performing a
11 delicate procedure, just her aggressive and just
12 demeaning behavior that had led me to commit certain
13 mistakes or even just be represented in a very
14 inaccurate way, just interactions we have in front of
15 students and in front of other staff, how I was, you
16 know, disparaged in front of the surgical team.

17 It's not just evaluations. It's her
18 behavior towards me as I'm in the middle of a
19 procedure where I'm looking to her for guidance and
20 instruction and she becomes my main detractor.

21 Q So other than how she interacted with you
22 in the OR, what she wrote about that in her
23 evaluations, and her conversations with other CRNAs
24 about your work, do you allege that Jill Wimberly did

Page 421

1 anything that created problems for you or that was
2 wrong?

3 A Those basically lead to multiple sets of
4 problems. She started, you know --

5 Q I just want to know if there is anything
6 else?

7 MS. SIEGEL: She is answering.

8 MR. LAND: No. She's not. It's nonresponsive.
9 She is talking about the same things. I'm asking her
10 if there is anything else.

11 MS. SIEGEL: Let her finish her answer. You
12 won't let her finish her answer.

13 MR. LAND: Q is there anything else?

14 A So all of my physical symptoms and
15 stresses that I had to endure because I had to deal
16 with the types of treatments that I had gotten started
17 by her, and then she had influenced other CRNAs to
18 treat me disparagingly. It's like I feel those things
19 are stemming from her actions.

20 Q Is there anything else she did that you
21 claim was wrong or created problems for you?

22 A I can't say for certain. That's all that
23 I can think of right now; but I know that, you know,
24 she had actively put me in jeopardy that eventually

Page 422

1 led to my failure.

2 Q So you were dismissed from the SRNA
3 program because of your grades; right?

4 A Yes.

5 Q And that was based on an evaluation of
6 your work in the clinical course; is that right?

7 A Yes.

8 Q Is the clinical course part of the
9 curriculum for the SRNA program?

10 A Yes.

11 Q I think you testified in the first session
12 that during your clinical time, you stayed in the
13 one-on-one supervision component of the clinical
14 program; right?

15 A Yes.

16 Q Did you get paid any money by Rush when
17 you were in the didactic component of the program?

18 A No.

19 Q Did you ever start receiving a stipend
20 from Rush?

21 A Yes.

22 Q When did you start receiving that?

23 A I'm not sure if we started getting it at
24 the start of residency or even before that.

Page 423

Page 425

1 Q Are you sure you received the stipend?
 2 A Well, that's what they said. It was a
 3 stipend.
 4 Q You received a payment of money from Rush?
 5 A Yes.
 6 Q But you don't know when you started to
 7 receive it?
 8 A I don't recall exactly, but I think it
 9 might have been the start of residency.
 10 Q When was that then?
 11 A Probably late May or early June.
 12 Q Of 2013?
 13 A Yes.
 14 Q Was that amount a specific amount per
 15 month?
 16 A I think it was roughly around \$800.
 17 Q Did it relate to how much work you did,
 18 how much time you spent?
 19 A No.
 20 Q Did it relate to how many hours you spent
 21 in the OR?
 22 A No.
 23 Q So you could spend 40 hours or 2 hours in
 24 the OR and you would still receive the same amount of

1 Q Did you think that the CRNAs should
 2 evaluate you as if you were no longer a student, no
 3 longer learning?
 4 A I don't really understand that question.
 5 Q Really? I thought you were saying that
 6 you thought that they were evaluating you too harshly
 7 because they were treating you as you were further
 8 along in the program. Wasn't that part of your
 9 concern?
 10 A That, but it's the inaccuracy of their
 11 evaluation where I had a minor miscommunication, and
 12 that was graded like very harshly. So it's not
 13 commensurate to really what happened for me to be
 14 given a 0 even though I had done, you know, more
 15 other, several things went accordingly.
 16 Q You didn't think that they should hold you
 17 to the same standard of performance as someone in the
 18 rotational stage of clinical residency, did you?
 19 A Well, I hoped that they would give me a
 20 little consideration from when I had to restart in my
 21 LOA and not compare me with my classmates who never
 22 had an interruption with their training, had five
 23 months of training ahead of me. So I was hoping that
 24 they would look at that as a consideration in grading

Page 424

Page 426

1 money; right?
 2 A Yes.
 3 Q How did the clinical residency fit into
 4 your overall education in the program?
 5 A It's partly training and partly that at
 6 the point when we were independently practicing, then
 7 we're doing the actual anesthesia provision as part of
 8 the residency.
 9 Q And you never got to the part where you
 10 did the independent anesthesia part; right?
 11 A No.
 12 Q Because you were always in the one-on-one
 13 supervision?
 14 A Yes.
 15 Q So was it always educational?
 16 MS. SIEGEL: Calls for a legal conclusion.
 17 A I don't know.
 18 MR. LAND: Q You don't know?
 19 A That's what they would call it because we
 20 were considered employees, and we signed a contract
 21 that basically we were being offered a position of
 22 SRNA based on that contract. We went through
 23 employment orientation and got retirement benefits
 24 that called 403b.

1 me.
 2 Q Did you still have classes during your
 3 clinical residency?
 4 A We had case presentations and journal
 5 clubs, journal article presentations.
 6 Q When you were in the one-on-one
 7 supervision component of your clinical residency, what
 8 would you say was the dominant purpose of your role
 9 there? What was the primary goal for you?
 10 A Well, training to learn different cases
 11 and learn how to provide anesthesia for different
 12 cases.
 13 Q In every case you worked on, a CRNA was
 14 there with you; right?
 15 A For the most part.
 16 Q And they could have done what you did
 17 without you there; right?
 18 A Yes.
 19 Q How much was your stipend?
 20 A I think it was \$800 a month.
 21 Q How many hours do you think you worked in
 22 the OR in July of 2013?
 23 A Probably around 60 hours a week.
 24 Q 60 hours a week?

Page 427

Page 429

1 A Yes.

2 Q For \$800 a month; right?

3 A Yeah, yes.

4 Q And that didn't vary based upon how much
5 you worked; right?

6 A Yes.

7 Q Do you allege that you have vacation days
8 allotted to you that were paid?

9 A Well, it's part of the residency that we
10 are given that; but it does not decrease the amount of
11 stipend that we got for that month. If we took that
12 vacation -- I think it's 20 days -- we still got that
13 \$800 regardless.

14 Q So vacation days were days you could -- it
15 was like an amount of time that you could take off?

16 A Yes.

17 Q When you got dismissed from the program,
18 did you get paid for any remaining vacation days?

19 A No.

20 Q Did you expect to be?

21 A I just recall that I think I got a check
22 after I was dismissed for that because it's like by
23 every two weeks that we get paid. I think that last
24 week I still got a check.

1 week in the OR in July of 2013, do you also study
2 outside of that time?

3 A I mean it's part of the -- You're doing
4 the case. You study on your patient and the
5 particular case the night before. So in between you
6 would study, of course. And in the weekends we'd
7 study boards I guess.

8 Q How much time would you spend a week on
9 that kind of studying and preparation?

10 A So depending on my case loads, I have to
11 look up the patients, look up their cases, call them,
12 talk to the attendings, prepare a care plan, study
13 their drugs and then on the weekends study some boards
14 or things that I feel I need to familiarize myself
15 with the cases that I've had for the week.

16 So if it's a typical weekday, then I
17 would probably spend an average of four hours studying
18 and putting together patient information for my cases
19 the next day. So that's four hours a day. Then on
20 the weekend I probably studied about eight hours per
21 day.

22 Q So it was a lot?

23 A Yes.

24 Q Did anyone ever tell you how much of that

Page 428

Page 430

1 Q Did you receive academic credit for the
2 time that you spent in clinical residency?

3 A I believe so. I don't know how many
4 credits it amounted to, but I think so.

5 Q You received a no pass for the clinical
6 residency in 2013; right?

7 A I think it's NP/ something. I forgot.

8 Q Then a no pass for the residency in the
9 spring of 2014?

10 A Yes.

11 Q And you paid tuition to Rush at the same
12 time?

13 A Yes.

14 Q How much was your tuition for 2014; do you
15 remember?

16 A Well, the clinical residency part, I think
17 it was something like 3,000; but there was also a
18 capstone part which I paid. But I was already
19 dismissed, and he said not to come back.

20 But, nonetheless, I was failed for that
21 course which it's already been paid. He didn't let me
22 come back, and then he gave me a no pass for a class I
23 never attended.

24 Q When you said that you worked 60 hours a

1 you needed to do?

2 A No.

3 Q It was up to you; right?

4 A Yes.

5 Q Did you get any other benefits besides
6 vacation and stipend when you were in the SRNA program
7 in the clinical residency component?

8 A The 403b. That's the retirement benefits.
9 Insurance was through the student, I think part of the
10 student benefits.

11 Q What insurance?

12 A Health insurance.

13 Q Did you have a health insurance during
14 didactic portion of the program too?

15 A Yes.

16 Q So is it just the stipend and the 403b
17 that changed during the residency program?

18 A Well, we also got yearly bonuses that the
19 anesthesia had, so it would give us -- So it's like
20 gift cards, yep. That's from what I remember.

21 Q When did you get a gift card?

22 A When? Around Christmas time.

23 Q Of what year.

24 A Of 2013, 2014.

Page 431

Page 433

1 Q From whom?
 2 A Dr. Tumen and the anesthesia department I
 3 assume, but Dr. Tumen signs the card.
 4 Q So is it from him personally or from Rush?
 5 A I think it's from anesthesia, the
 6 anesthesia department because I don't think other
 7 colleges got that.
 8 Q When you say the anesthesiology
 9 department, do you mean not from the College of
 10 Nursing?
 11 A Yeah. I think that's from just the
 12 Department of Anesthesia.
 13 Q And was your clinical residency organized
 14 by academic term?
 15 A I believe so.
 16 Q That was while you were told your leave of
 17 absence had to extend longer than you wanted; right?
 18 A That's what they told me; and Dr. Wiley
 19 said I could take two weeks or one month, and then
 20 they changed that. Dr. Kremer decided it's not
 21 feasible to do a two-week, one-month leave.
 22 Q Were you ever promised paid employment at
 23 Rush upon graduation from the program?
 24 A No.

Page 432

1 Q You would have had to apply for it and be
 2 selected by Rush when you graduated; right?
 3 A Yes.
 4 Q Do you know how many of your classmates
 5 from your original cohort were employed at Rush as
 6 CRNAs after they graduated?
 7 A Well, Rush has other satellites. Great
 8 Lakes, I think Skokie might be one of them, and Oak
 9 Park is one of them. Like the off sites that we
 10 rotated are Rush affiliated, so I'm approximating
 11 roughly 80 percent got employed by the Rush system and
 12 networks.
 13 Q But not at the Rush University Medical
 14 Center in the city?
 15 A I think there were four of them that got
 16 employed by Rush from my cohort.
 17 Q Four out of how many?
 18 A 28.
 19 Q When you learned of your no pass grade in
 20 residency in 2014, you filed a grade appeal; right?
 21 A Yes.
 22 Q And after that you also appealed your
 23 dismissal from the program; is that right?
 24 A Yes.

1 Q Did you do anything else to challenge
 2 those internally within Rush?
 3 A Internally?
 4 Q Yeah.
 5 A Well, I had frequent interactions with the
 6 dean. Basically I wasn't sure, you know, how this
 7 process went.
 8 So I was supposed to be meeting with
 9 Dr. Kremer, and he had canceled on me twice. And then
 10 I had to just confer with Dr. Foreman as to how I
 11 needed to progress with this appeal or what I needed
 12 to do to appeal my grade or appeal my dismissal.
 13 Q So you were contesting your treatment as a
 14 student with respect to your grades and your dismissal
 15 from the program; right?
 16 A Yes.
 17 MR. LAND: Could you give me a minute to take a
 18 break and see if I have any other questions?
 19 MS. SIEGEL: Yeah. If we can wind up about
 20 now, that would be good.
 21 (Whereupon a brief recess was had,
 22 after which the deposition of
 23 Ms. Marcial continued as
 24 follows:)

Page 434

1 MR. LAND: Back on the record.
 2 So I have no further questions for
 3 today, and the only reason I say today is the
 4 tape-recording issue that we need to resolve. So for
 5 that purpose I leave the deposition open meaning we
 6 have sought forensic evaluation of plaintiff's
 7 cellphone, have an indication of I think it's 13
 8 recordings; but we have not had a chance to review
 9 those. We're going to work out how we do that. And
 10 depending upon what we learn about those recordings,
 11 we reserve the right to depose the plaintiff further
 12 about those recordings.
 13 MS. SIEGEL: Okay.
 14
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 22
 23
 24

--ooOoo--

Page 435

1 UNITED STATES DISTRICT COURT)
NORTHERN DISTRICT OF ILLINOIS) SS.
2 EASTERN DIVISION)
3
4

5 I have read the foregoing transcript of my
6 deposition, taken on March 19, 2018, consisting of
7 Pages 337 through 434, inclusive, and I find it is a
8 true and correct transcript of my deposition so given
9 as aforesaid.
10
11
12
13
14

15 MARICEL MARCIAL

16
17 SUBSCRIBED AND SWORN TO
before me this _____ day
18 of _____, 2018.
19

20 Notary Public
21
22
23
24

Page 436

1 STATE OF ILLINOIS)
) SS.
2 COUNTY OF COOK)
3
4

5 I, Erin McLaughlin, CSR, do hereby certify
6 that I am a court reporter doing business in the City
7 of Chicago, that I reported in shorthand the testimony
8 given at the deposition of MARICEL MARCIAL, on
9 March 19, 2018, and that the foregoing is a true and
10 correct transcript of my shorthand notes so taken as
11 aforesaid.
12
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17 Certified Shorthand Reporter
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able 338:6 347:10 352:18 354:4 366:10 377:12,14 382:2 389:22 absence 369:8 377:23 414:17,22 414:24 416:6 431:17 academic 428:1 431:14 acceptable 396:13 accidentally 349:9 349:11 account 391:7 accountable 378:10 accuracy 412:23 413:6 accurate 339:9,15 339:24 341:8 346:6 349:21 353:1 365:20 367:23,24 368:1,3 373:7,16 377:13 384:22 390:8 395:6 401:6 accurately 348:9 accustomed 385:18 acted 410:24 412:2 412:7,9 413:2,14 414:4 415:22 416:10 acting 415:1 417:21 action 402:3 419:19 actions 421:19 actively 421:24 Activity 365:18 actual 378:19 390:4 410:21 424:7 added 386:23 389:4 406:16 additional 387:16 address 343:11,18 343:21 360:9,10 382:9	addressed 343:14 addressing 374:2 add-on 382:14,18 385:1 386:7 adjunct 392:20 adjusting 353:13 354:10 355:5 administer 391:16 administered 390:24 administering 347:12 378:17 adult 386:9 395:24 advanced 377:10 377:17 advancing 416:17 advisable 415:17 advocate 414:4 affect 347:7 383:12 390:9 392:22 affiliated 432:10 aforesaid 435:9 436:11 agency 411:1 aggressive 420:11 agree 358:4 381:24 401:9 414:20 agreed 341:9 348:4 399:5 ahead 425:23 airway 383:2,5 384:1 alert 350:7 algorithm 383:1 allegations 418:19 allege 420:6,24 427:7 alleged 412:3 alleges 410:21 alleging 402:10 allotted 427:8 allowed 405:4 Amended 401:20 amount 341:6,9,14 345:21 346:6,22 347:5 348:10	386:13 392:6,15 393:14 423:14,14 423:24 427:10,15 amounted 428:4 Amy 369:6 417:7 anesthesia 354:4,6 354:13 355:1,6 377:5,7,10,17 379:1 383:20 384:4 386:17 389:9 412:23 424:7,10 426:11 430:19 431:2,5,6 431:12 anesthesiologist 358:19 359:4 anesthesiologists 396:12 anesthesiology 431:8 anesthetic 375:20 382:23 389:23 anesthetics 339:5 aneurysm 382:5,6 382:17,24 383:4,9 383:21 384:5 Angela 400:24 answer 355:20 356:3,5 364:9 366:10,16 373:8 376:1,8 377:12,14 383:6,15 402:14 409:19 421:11,12 answered 366:17 383:17 answering 421:7 antihypertensive 383:23 anti-hypertensive 383:24 anybody 349:24 350:8 anymore 356:3 415:16 appeal 432:20 433:11,12,12	appealed 432:22 appeals 344:15 appear 337:19 appearance 344:15 397:2 APPEARANCES 335:1 appeared 335:6,12 390:2 appears 338:18 345:8 apply 432:1 approach 381:6 approached 350:11 350:22 380:21 approximating 432:10 April 372:19 378:4 405:9 apt 380:22 argued 406:22 Argumentative 409:17 arm 349:11,18 350:3,6 351:7 arms 351:9 arose 347:24 arrived 368:6 article 426:5 ASA 365:16 aside 379:1 406:10 asked 351:3 364:12 366:5 369:9 373:3 373:4,12,19,23 374:4,10 375:1,22 375:24 376:2,11 376:15,24 377:2,9 377:16 381:2 382:12 392:24 393:2 398:11 405:14,23 406:7 asking 341:15 343:12 353:24 363:12 365:8 366:1 382:22 402:17 406:23	408:18 417:6,10 418:17 419:1,5,14 421:9 asks 411:24 aspirin 365:16 assertions 418:3 assessing 356:20 assessment 365:20 assessments 365:7 assign 406:6 assigned 405:18,20 405:23 406:1,7,19 417:9 418:11 assigning 407:4 417:1 assignment 407:21 ASSOCIATES 335:3 assume 431:3 assumed 385:22 assured 407:17 as-needed 347:24 attempt 388:12 attended 428:23 attending 358:18 385:15 attendings 429:12 attention 360:4 419:23 average 429:17 avoid 369:18 370:24 avoided 370:20 avoiding 368:23 369:10
				B
				B 343:8 344:3 371:18,21 383:1 back 350:18,23 354:10 360:2 364:22 369:7,8,11 371:10 374:22 378:1,7 385:14 398:4 413:23 414:19 415:5,15

415:16,18 419:20 428:19,22 434:1 based 343:24 381:8 399:7 404:2 417:15 422:5 424:22 427:4 basic 367:15 377:5 377:6 379:1 basically 373:10 389:3 399:24 412:20 414:5 415:7,9,17 416:14 416:21 419:15,18 421:3 424:21 433:6 basis 404:3 bat 407:11 beginning 366:13 366:21 380:16,21 begins 400:4 begrudgingly 414:16 behalf 335:6,12 337:2 behavior 409:8 420:8,12,18 behaviors 339:7 408:5 belief 404:4 beliefs 414:3 believe 338:12 385:10 413:2 418:2 428:3 431:15 believed 407:6 408:20 413:1 believing 414:24 belonged 375:8 beneath 402:19 benefits 424:23 430:5,8,10 best 344:16 373:24 410:9 413:20 better 368:9 bias 417:18 black 340:3	BLACKWELL 335:8 blank 376:5,24 bleeding 374:1 379:13,13,15 383:14 block 352:12,13 blood 348:6 362:5 362:11 382:3 383:14 Blvd 335:3 boards 429:7,13 bonuses 430:18 bottom 337:19 349:6 367:13 379:3 384:16,24 411:24 brain's 383:12 brand 409:11 break 401:13 433:18 breathing 383:2 brief 357:3,7 401:14 433:21 bringing 360:6 378:20 brings 360:3 brink 376:4 brought 361:15 367:17,19 405:6 bump 349:18 bumped 350:3,16 bumping 350:10,14 bundle 372:2 business 436:6 busy 350:5 351:6 406:15 button 392:13 <hr/> C <hr/> C 371:18 383:1 call 344:6 367:20 368:4,10 383:22 424:19 429:11 called 334:13 337:2 348:2 350:2 368:6	416:3 424:24 calling 402:15 407:9 415:4 calls 402:7 412:10 418:22 424:16 canceled 433:9 cancer 388:6 canister 361:1,17 362:10,23 363:20 canula 389:13,20 capacities 402:5 capacity 334:7,8,9 402:18 capstone 428:18 card 430:21 431:3 cardiac 366:9 391:19 392:23 395:20 396:3 397:3 cards 430:20 care 429:12 careful 391:20 caring 352:14 case 338:14 339:3 339:20 340:1 342:19 345:5,10 347:22,22 351:13 353:7 355:24 360:11 364:18 365:1 368:7,20 369:16 371:14 372:19 376:12 378:16,20,21 379:22 380:22 382:14,15,18,21 384:2 385:1,2,8 386:2,7,8,9,22 387:8,13,19 388:22,24 389:3,4 391:4 418:13 426:4,13 429:4,5 429:10 cases 356:16 361:11 375:18 377:24 378:16 379:23 385:10,12	386:5,7 387:21 391:9 398:20 406:15 417:9 420:9 426:10,12 429:11,15,18 catch 419:23 categories 338:1 348:20,21 360:19 367:10 387:11 category 374:11 375:7 380:12 caught 390:19 391:2,14 cause 351:11 396:3 402:2 caused 379:4 cellphone 434:7 center 334:6 383:12 432:14 cerebral 382:5,6,17 382:24 383:20 384:5 certain 344:9 345:19 358:1 369:12 378:13 398:21 412:22 417:18,19 420:12 421:22 certainly 363:10,22 377:21,24 385:8 413:4 Certified 436:17 certify 436:5 cetera 365:19 366:10 challenge 433:1 chance 391:13 415:18 434:8 changed 430:17 431:20 changes 352:18 353:11 354:23 changing 354:16,24 chart 346:17 352:12 charted 346:18	cheat 375:3 check 392:7,11,19 393:13 404:12 412:22 427:21,24 checked 392:5,5 checking 392:15 393:17 395:14 chest 420:10 Chicago 334:18 335:4,9 436:7 choice 414:22 Christmas 430:22 circulating 350:7 350:17,19,21,22 circulation 383:2 383:13 city 432:14 436:6 Civil 334:15 claim 354:18 403:23 417:12 421:21 claiming 354:21 clamp 357:3 clamped 357:4 clarification 339:6 367:16 clarify 339:22 class 374:8,9 428:22 classes 377:10,17 426:2 classmates 425:21 432:4 clean 362:4,6 clear 363:22 clinical 343:8 345:13 387:14 389:22 422:6,8,12 422:13 424:3 425:18 426:3,7 428:2,5,16 430:7 431:13 Clinically 381:20 close 415:6 clubs 426:5 cocks 357:19 358:8
---	--	---	--	--

358:11,20,24 359:3 cohort 432:5,16 Colino 360:16 363:8,17 364:1 387:2,8 391:16 394:6 395:15 397:7 collected 384:19 College 431:9 colleges 431:7 come 366:11 414:18 415:15,16 415:17 418:24 428:19,22 comes 366:7 comfortable 369:13 coming 350:23 382:18 417:4 commencing 334:19 commensurate 425:13 comment 338:5 357:8 comments 352:8 360:22 365:6 367:12 387:17 391:24 407:20 418:4 commit 420:12 committee 344:16 compare 425:21 comparison 400:23 complaint 401:20 410:19 412:4 complaints 413:10 416:7 complete 416:4 completed 371:14 completely 366:11 complicated 338:6 comply 414:22 component 422:13 422:17 426:7 430:7	concede 341:21 concentration 346:12,21 347:13 354:24 385:4 concept 377:5 concepts 377:7 concern 392:2 396:1 425:9 concerned 375:24 376:10 conclusion 341:10 382:12 402:8 412:10 415:4 418:22,23 419:4 424:16 conclusions 340:21 413:17 condition 347:8,8 389:15 391:19 396:8 confer 433:10 confirm 395:2 401:9 confirmed 394:19 400:17 confronted 419:20 confused 396:22 confusion 339:21 connected 357:2 361:12,24 362:8 364:13 connection 362:12 connects 362:11 conservative 356:1 356:14 consider 396:12 414:18 consideration 382:23 425:20,24 considered 376:2 376:16 412:17 424:20 considering 393:3 393:12 395:4 396:7 413:9 419:16,17	consistently 354:17 416:8 consisting 435:6 constant 342:17 constantly 347:19 352:22 353:12 359:3 contact 370:15 contain 362:10 365:3 contained 372:21 contains 383:22 contaminated 349:7 contemporaneou... 342:15 343:21 contention 412:1 contesting 433:13 continually 402:23 403:12 continued 334:12 394:18 401:16 433:23 Continues 413:16 contract 401:23 424:20,22 contrary 411:2 control 354:19,20 382:4,5 383:14,14 409:8 Cont'd 337:7 conversation 339:23 364:16 407:3,22 conversations 344:8 420:23 COOK 436:2 coordinating 406:15 copy 401:19 core 400:12 correct 339:22 341:10 346:2,4,9 346:22,22,23 371:21 373:14 393:14 435:8	436:10 correctly 347:5,6 395:15 Coumadin 365:14 counseling 407:13 count 401:22 COUNTY 436:2 couple 349:6 course 375:14 382:24 416:12 422:6,8 428:21 429:6 courses 378:1,3 court 334:1 435:1 436:6 COURTHEOUX 335:11 Courts 334:16 covered 349:14 357:23 CO2 387:17 create 420:7 created 349:21 419:9 421:1,21 credence 416:22 credible 404:24 credit 404:14 428:1 credits 428:4 criticisms 414:8 criticize 353:23 criticized 408:14 CRNA 370:24 389:21 390:15,24 404:20 410:24 411:6,13 412:19 416:22,23 417:4 419:8 426:13 CRNAs 368:17,20 369:3,4,10,12 380:23 400:6,9,13 400:21,21 401:4,7 408:4,20,24 411:17 413:1 414:24 416:20 418:4,19 419:8 420:5,23 421:17	425:1 432:6 CRNA's 402:23 cross 401:10 CSR 334:17,24 436:5 curriculum 422:9 cut 366:1 376:18 D D 336:1 338:18 340:17 343:9 344:4 da 349:9,18 350:3 damage 379:4 date 340:15 366:4 dated 337:20 380:3 384:16 dates 344:14 345:8 day 338:4 342:4 343:2,6 348:23 349:19 360:7 361:5,6,18 362:2 362:16 363:1,2 365:21 366:15 370:9,21,23 378:17 379:7,10 381:2,20 384:23 385:7,23 386:18 386:24 394:5,8 398:21,23 406:13 406:20,21,24 407:1,5,21,22 429:19,19,21 435:17 days 427:7,12,14 427:14,18 deal 416:18 421:15 dean 433:6 decide 356:2 decided 360:9 412:19 431:20 decrease 374:1 427:10 decreased 375:20 376:4 deepened 375:20
---	--	---	--	---

375:21	different 360:19	341:10 382:7	412:7 419:15,21	either 343:22
Defendant 335:12	367:10 375:4	397:4	420:1 431:2,3,18	397:24 398:24
defendants 334:10	386:21 395:9	distance 415:6	431:20 433:9,10	ejection 392:22
334:13 337:2	401:7 407:17,18	distract 351:7	draw 356:2 372:14	396:7
401:23 402:4,20	426:10,11	distracted 350:15	388:2,16,22	Elaine 335:3,5
410:22 412:1	difficult 367:14	351:10	drawing 378:24	402:18 418:24
definitely 362:7	385:1 415:19	District 334:1,1,16	379:20	email 370:3,8
403:24 407:9,15	difficulties 400:19	435:1,1	drawn 379:11,24	397:16
417:3 418:9	407:18	DIVISION 334:2	388:21	emailed 399:1
deleting 404:18	difficulty 388:4	435:2	drew 348:5 388:3,3	emails 370:1
delicate 420:11	diligence 413:7,10	document 351:21	388:17	embolism 366:9
delusional 416:3	dinged 347:7	364:2,18 394:1	drip 355:22 388:13	emergency 383:23
demeaning 413:19	direct 337:7 362:12	396:19 410:6,15	394:18	employed 432:5,11
420:12	directed 368:19	documents 337:16	drips 383:23	432:16
demonstrates	direction 358:5,6	doing 353:18	drug 346:8,11,12	employees 424:20
388:4	358:12	368:23 374:2	346:21,23 347:12	employment
department 431:2	directly 360:22	408:8 415:11	347:19,20 348:5	424:23 431:22
431:6,9,12	361:23 362:8	424:7 429:3 436:6	348:10 373:9,10	emptying 350:1
depending 429:10	363:19 364:11	dominant 426:8	373:23,24 374:4	encounter 344:1
434:10	370:16	door 398:22	374:11 375:7	406:18 418:10
depose 434:11	discredit 412:20	dosage 385:1 395:4	379:21 385:1	encounters 408:2
deposition 334:12	discrimination	395:14 396:3,17	388:17 391:16	ended 361:11
337:11,12 369:21	403:2 407:7	dosages 340:22	drugs 347:24 375:4	endoscope 391:24
369:24 393:21	discriminatory	341:11	378:10,13,15,19	ends 351:23
401:15,19 433:22	408:1	dose 346:8 347:5	378:21 379:1	endure 421:15
434:5 435:6,8	discuss 353:22	373:4,5,12,14	388:21 429:13	enter 365:18
436:8	discussed 364:8	385:4,17,24	due 413:7,10	entirely 341:8
depositions 334:17	discussing 394:12	392:13,17 393:2	duly 337:3	352:6 355:21
depress 392:23	discussion 416:13	393:11 395:1,23	dump 391:10	367:24 369:15
described 353:6	dislodged 375:23	397:3,5	dumping 349:12	entitled 414:13
390:9	376:7	doses 339:5 389:21	duty 414:3	environment 342:7
description 366:4	dismissal 432:23	dosing 338:21	dyslexic 347:17	349:22
384:22	433:12,14	341:7 342:2	D&C 374:2 379:14	envision 416:5
despite 338:6 346:7	dismissed 360:1	Dr 334:7 338:18		epidural 338:22
394:17 404:13	384:11,20 398:19	339:15 340:20	E	equipment 358:9
412:21 413:20	418:12 422:2	342:5,9 343:5	E 336:1 345:15	361:19,22
details 360:7	427:17,22 428:19	344:6 345:5 348:2	ear 420:10	erased 349:15
376:22 404:7	disoriented 357:24	351:5 360:3	early 423:11	Erin 334:17,24
determine 354:5	disparaged 420:16	361:15 364:8,12	EASTERN 334:2	436:5
404:22	disparaging 403:18	364:17 370:15	435:2	erosions 392:2
detractor 420:20	407:10 413:19	371:4,14 372:9	ECT 386:20	error 341:22 342:2
detrimental 388:4	415:10	380:21 381:6	education 424:4	351:11
didactic 377:11	disparagingly	397:11 398:17	educational 424:15	esophageal 388:6
378:11 422:17	421:18	399:21 400:15,16	EF 388:7 391:20	392:2
430:14	disproves 354:18	404:9 407:11	efforts 413:20	esophagus 392:4
didactics 377:22	dispute 340:21	408:12 411:10	eight 429:20	especially 345:2

378:13 391:10 396:6,13 establish 364:14 383:8 estimate 356:15 et 365:19 366:10 Eva 351:13,24 352:4 355:8 357:11 401:1 403:16,18,22 404:4 eval 368:24 evals 369:4,6 413:23 evaluate 369:11,16 370:24 411:5,10 425:2 evaluated 406:24 418:18 evaluating 342:11 342:22 369:14 417:13 419:6 425:6 evaluation 337:20 338:3,8,11 339:23 340:14 341:3 342:15 343:5 345:5,9 346:3 348:13,19 351:13 351:24 352:4 353:8 355:8 359:8 359:12,16,20 360:13,15,18 362:15 363:18 364:1,24 367:1,4 367:21 368:13 369:13 370:10 371:6,13 372:18 372:21 380:3,8 381:11,14 384:6 384:12,15,18 387:2,4,7 394:5 394:11 397:7 398:12,13 403:22 403:23 404:1,10 404:11,13 405:3	405:13 406:4 407:6 419:18 422:5 425:11 434:6 evaluations 342:6 344:12 360:1,3 368:20 369:10 370:20 380:24 384:20 399:11 400:14 402:24 403:5,13 404:14 404:19,21 408:16 411:14 412:17,22 412:24 413:5,7,8 413:11,21 414:24 416:20 418:3 419:6,11,23 420:4 420:17,23 evaluator 380:14 Evelyn 399:3 event 390:24 408:6 408:8,10 eventually 391:15 421:24 everybody 415:9 exact 344:14 404:7 410:16 exactly 353:8,22 366:18 423:8 examination 334:14 336:8 337:7 examined 337:3 example 365:9 370:19,23 Exhibit 337:11,13 337:15,18 340:7 341:2 343:6 344:11,22 345:3 348:13 351:12,20 359:8,14 360:13 364:3,24 369:21 369:24 371:10 384:12 393:20,21 393:23 399:22 400:2 401:19	411:19 416:1 EXHIBITS 336:16 expect 427:20 expected 338:19 343:9 371:18 experience 383:1 400:12,24 experienced 400:18 expires 355:13 explain 410:8 explained 339:18 357:5 372:12 explaining 386:4 399:23 explanations 412:21 414:2 explicitly 388:8 exposed 377:24 378:14 extend 431:17 extensive 366:16 extent 407:23 extubate 362:4	falsehoods 420:2 familiar 347:20 378:14 400:17 familiarize 429:14 far 344:24 feasible 399:6 431:21 February 337:20 338:15 340:12 341:3 345:6,10 348:16 351:14 370:4 feedback 418:11,13 feel 381:6 396:6 406:17 421:18 429:14 felt 338:4 395:1 400:13 406:16 408:3 Fentanyl 388:2,4 388:16,17,22 390:14,16,23 391:4,14 394:17 fibroids 374:3 fidgeting 352:23 353:12 354:2,7,18 field 349:7 fifth 370:8 fight 414:20 fighting 354:3 file 404:19 filed 413:9 432:20 files 404:21 fill 368:17 369:1 filled 369:3 384:21 find 350:8 411:19 435:7 fine 383:9 392:8 finish 421:11,12 finished 377:11 389:4 391:5 first 342:4 344:21 348:2 350:23 367:18 383:5,16 390:5 397:9 401:21 404:3	422:11 Fisher 351:13,24 352:4 355:8 357:11 401:1 403:22 404:5 fit 424:3 five 372:3 414:17 425:22 five-month 414:21 flagrantly 419:12 flipped 347:15 flipping 358:2 Foley 349:12 350:2 follow 355:12 followed 408:5 following 388:5 412:1 follows 337:4 389:19 401:17 433:24 foregoing 435:5 436:9 Foreman 370:4 433:10 forensic 434:6 Forester 401:1 forget 378:13 forgot 381:1 428:7 forgotten 378:1 form 366:5 367:22 368:13 370:10 371:6,13 forth 354:10 forward 392:24 408:11 founded 396:10 four 372:3 429:17 429:19 432:15,17 fourth 394:14 fraction 392:22 396:7 frail 389:18 frequent 433:5 fresh 414:19 Friday 397:16,19 398:3,5,7 399:5
---	---	---	--	--

406:22 Fridays 399:9 front 406:20 415:10 420:14,15 420:16 full 361:20 391:3 407:23 420:2 function 392:23 functions 367:15 383:11 further 337:4 425:7 434:2,11	427:10 435:8 436:8 giving 354:11 369:3 369:10,13,18 379:5,7 385:18 392:6,12,14,16,20 404:14 416:22 GlideScope 367:20 368:4 go 344:6 360:1 364:22 383:1 388:12 390:12 412:19 416:21 goal 426:9 goes 413:22 going 337:12 354:10 355:24 359:1 365:22 373:10 378:15 393:5,15 397:1 401:18 406:18 409:9,10 410:5 414:16 415:20 434:9 good 356:3 381:20 433:20 gotten 359:24 421:16 grabbed 390:16 grade 344:19 432:19,20 433:12 graded 425:12 grades 422:3 433:14 grading 344:7 425:24 graduated 432:2,6 graduation 431:23 grasping 377:5 Great 432:7 grid 375:4 grounds 419:16 group 400:6,8,13 400:21 412:19 417:18 guarantee 408:24	guarantees 407:18 guess 342:21 347:14 348:8,24 364:21 385:6 395:7 397:4 401:8 415:19 416:20 429:7 guidance 420:19 guide 346:22 guys 374:6	409:12 410:1 harshly 425:6,12 haste 348:8 head 374:12 397:4 415:24 health 430:12,13 hear 383:16 408:13 heard 385:16 386:11,12 408:19 417:3 heart 375:19 376:4 Heather 348:14 350:9 351:2 held 419:20 help 354:6 358:6 374:1 381:22 408:13 Hemabate 373:19 373:22 374:4,13 374:14,18,22,24 375:4,6,10 Hemodynamics 352:21 hide 350:13 hiding 350:20 high 397:3,5 higher 385:24 history 397:1 hit 349:11 350:4 hold 378:9 388:15 425:16 hooked 360:22 363:9,19 364:11 hoped 425:19 hoping 419:24 425:23 hour 334:19 379:16 hours 355:9,22 356:1,6 396:14 423:20,23,23 426:21,23,24 428:24 429:17,19 429:20 Housekeeping 361:18 huge 373:20 374:17	hurdles 407:17 hurried 391:12 hurry 365:24 HUSCH 335:8 Hydralazine 347:16 348:4 385:3,13,16,21 386:8,13 hypertensive 347:9 348:1,3
G		H		I
G 335:11 ganging 415:9 gases 354:11,24 355:5 gastroenterologist 392:1 Gawura 417:7 generally 380:15 getting 350:2 370:20 371:5 377:2 417:9 422:23 gift 430:20,21 give 339:17 341:6,8 341:9,14 346:6,6 348:3,6 351:16 364:9 368:18 369:15 370:10 373:6,8 379:10,14 380:24 381:1 385:3,16,17 386:10,14 388:8 390:13 391:3 392:21 397:3 399:21 415:18 425:19 430:19 433:17 given 367:21 368:12 369:4,6 372:15 379:12 389:21 390:20,20 414:15 425:14		H 374:10 hair 389:11,12 half 349:17 356:14 379:16 386:14,14 408:9 hand 337:13 375:20 401:18 408:4 handed 337:10 369:23 handled 414:23 handwriting 349:5 360:21 handwritten 352:8 356:18 365:6 367:12 388:1 389:7 happen 349:16 352:16 356:23 358:20 361:9 373:7 386:18 388:19 407:18 happened 350:1 353:4,5 359:24 360:7 381:11,12 390:18 425:13 happening 353:2 379:15 harassing 407:9,24 harassment 403:2 407:7 hard 408:12 harder 416:21 harsh 407:16		ICU 347:19 358:10 382:24 396:11 idea 368:9 identification 369:22 393:22 identified 347:5 400:12 identifies 353:10 identify 382:3 ignored 405:7 ignoring 416:7 II 338:17 III 343:8 345:13 Illinois 334:1,18 335:4,9 435:1 436:1 imagine 344:15 358:23 366:17 402:9 impeded 402:22 implications 383:20 384:4 409:7 implored 404:12 importance 382:3 important 342:5 365:8 389:24 importantly 379:4 improperly 361:13 improve 347:8 414:11 inaccuracy 425:10 inaccurate 356:4 420:14

inadequate 392:18 393:3,11 395:2	357:9 358:5 396:14	381:13,16	406:6,19,20,24 407:21,22 408:6 411:5 416:7,8 417:1,11 419:5 420:6,24	370:14 375:23 385:4 394:21 419:19,22
include 352:3 364:17 404:20	infusion 392:11	interrogatory 337:14 411:20,23 416:2	Jillian 369:19 370:10,12,16	know 339:4 340:22 341:11 342:14 343:18 346:5 347:11 349:10 351:7 352:3 353:3 353:16 354:9 355:9,17 356:4,15 358:3,4,22,23 360:10,11 362:1,9 362:20,22 363:6 363:21 364:7 366:19 367:24 373:5 374:11,18 374:19 376:23 377:1,3 382:11,19 383:19 384:4 385:1 388:7 393:10 396:21 397:1 403:8,16,17 403:20 406:11,16 406:21,24 407:2,4 407:23 409:3,6,9 412:13 413:8,23 414:8 415:8,16 416:12,19 417:5 417:19,21 419:21 419:22 420:16 421:4,5,23,23 423:6 424:17,18 425:14 428:3 432:4 433:6
included 364:2,21	inhibitor 374:13,15 374:24	interrupted 402:13	Jim 380:3,9,11,14 380:23 381:17 384:15	
including 404:19	inject 372:6	interruption 402:19 425:22	job 404:20 411:5,10 411:13,16	
inclusive 435:7	injected 371:22	intervention 382:5	JOSEPH 335:15	
incompatible 405:10	inside 351:9	interventional 382:16	journal 426:4,5	
incorrect 346:13,14	instances 413:22	intra 381:21	judgment 343:8 345:13 419:21	
incorrectly 346:17 347:2 364:15	institution 402:11	intubate 362:3	Judy 338:12 340:11 371:14	
increase 392:10 395:17 396:2,17	instructed 346:19 386:18 388:2,16	intubations 381:21	July 426:22 429:1	
increased 375:19 376:3 392:18	instruction 420:20	investigate 404:12 408:13 412:16 413:11	jumped 366:3	
increasing 393:4,12 395:4,13	instructions 388:5 388:5	investigating 408:16	June 403:9 405:12 405:18 408:6,8 423:11	
independent 424:10	instructor 415:10	involve 400:6	junior 374:8 375:13	
independently 381:22 424:6	instructors 415:8	iPad 342:14	juniors 375:1	
indicate 341:21 389:14,17 410:4	insurance 430:9,11 430:12,13	irrigation 349:3 362:6,10		
indicates 339:4 340:17 402:20	intended 339:21 350:19	irritated 415:14		
indication 434:7	intensivists 396:11	issue 346:7 349:16 349:21 353:9,11 358:12 379:19 403:24 404:8,9,15 405:2 406:4 434:4		
individual 334:7,8 334:8 402:4,18	intention 346:23 347:6 392:14	issues 366:19 402:3	K	
individually 402:5	intentionally 402:21 405:7 410:23	issuing 402:23 403:13,23 407:6	Karen 335:11 417:16,17	
inducing 410:23	intentions 363:21 417:2 418:9	items 343:22,23 344:3,7	karen.courtheou... 335:10	
induction 379:1 382:4	interacted 420:21	IV 357:1,19 373:6 379:6	Kathleen 367:7	
infallible 412:17	interacting 419:7		Katie 360:16 363:8 363:17 364:1 387:2,7 391:16 394:6 397:7	
influence 381:7	interaction 342:21 406:17 414:7 417:16	J	Keehn 401:1	
influenced 403:16 403:16,19,24 404:4 408:20 418:14 421:17	interactions 418:15 420:9,14 433:5	Jackson 335:3	keep 338:6	
information 346:14 383:3 417:24 419:19 429:18	interest 412:2 413:14,15 416:11 416:16,24	January 344:12 398:17 403:10 405:18 406:13 407:1,13	Keldahl 348:14	
informed 348:2 349:13 350:18	interested 397:12 397:18 398:15	jeopardy 421:24	kept 356:19	
infuse 358:7	interests 411:2	Jill 334:8 401:1 403:5,14,23 404:4 405:6,8,13,16	kilogram 388:6	
infusing 356:19	Interference 401:22		kind 347:20 429:9	
	internally 433:2,3		Klunk 369:19 370:12	
	interpreted 381:10		knew 342:19 356:7	
				knowing 378:10 knows 405:10 Kreiner 400:15 Kremer 334:7 351:5 360:3 361:15 364:8,12 364:17 368:19 370:15 371:4 380:21 381:6 397:11 398:17 399:21 401:23 402:20 404:8,9

407:11 408:12 410:22 412:7 419:15 420:1 431:20 433:9 Kremer's 411:10 419:21 K.B 335:3,5	373:20 375:5,9,11 378:11 432:19 learning 398:6 425:3 leave 369:8 377:23 398:21 414:17,21 414:23 416:6 431:16,21 434:5 lecture 374:13,16 374:19,20 375:15 lectures 377:20 led 418:13 419:15 420:12 422:1 left 361:3 362:24 legal 334:23 402:3 402:7 412:10 413:16 415:4 418:22,23 419:4 424:16 lengthy 355:24 letter 374:10 Let's 363:24 level 338:19 343:9 371:18 Lidocaine 338:24 340:4 372:13,16 388:23 lie 373:20 374:17 light 376:3 388:8 limiting 418:2 line 377:4 400:4 liquid 362:6 listed 343:15 listen 385:5 414:1 little 339:21 381:3 381:22 385:9,9,14 425:20 LMA 375:22,23 376:7 377:4,6 LOA 398:4,5 425:21 loads 429:10 local 339:5 382:21 long 356:7,17 357:9 365:24 longer 425:2,3	431:17 look 340:6 343:5 351:20 359:14 362:13 370:17 390:1,13 394:14 409:10 425:24 429:11,11 looked 350:5,6,10 350:10 361:10 374:22 376:5,23 389:24 394:18 401:20 409:12 410:5 looking 340:15 341:17 344:3 354:11 363:13 366:18 399:15 420:19 looks 373:2 391:3 lot 354:3,18,23 366:5 377:2 378:14 382:13 385:6 386:23 392:1 393:8 404:3 419:12 429:22 low 389:13,20,21 391:20 395:23	435:6 436:9 Marcial 334:3,13 336:4 337:1 369:21,24 393:21 401:16 433:23 435:14 436:8 Maricel 334:3,13 336:4 337:1,10 339:2 352:9 355:8 367:17 388:13 389:22 390:14 401:19 419:13 435:14 436:8 mark 393:20 marked 336:16 337:11,13,19 340:6 344:22 345:4 348:12 369:22,23 393:22 401:18 Marquis 370:3 Mary 364:24 372:18 401:1 mask 385:14 match 405:5 matter 413:23 McLaughlin 334:17,24 436:5 mean 342:18 344:7 353:3 376:11 387:20 396:5 400:8 403:12 418:24 429:3 431:9 meaning 434:5 means 353:17 361:12 383:4,13 meant 354:9 Medical 334:6 432:13 medication 347:4 medications 354:12 383:24 391:10 392:21 meds 373:13 377:9 377:16 388:8	meet 398:4,7 399:2 399:2,5,24 meeting 407:8,12 407:15,20 408:23 409:16 410:4,10 410:17 433:8 meetings 397:14,17 397:20 398:16 399:8,12 400:1 member 386:17 memory 360:9 MENDELSON 335:15 mentioned 362:15 398:10 400:15 416:13 message 403:20 met 413:18 Mether 379:5 Methergine 373:5 373:13 379:6,7,10 379:22,24 MICHAEL 334:7 mics 390:14,15 394:19 395:4,23 396:17 mid 402:13 middle 420:18 Mike 368:19 404:8 Miller 380:3,9,11 380:14 384:15 milligrams 339:4 346:5,18 347:16 347:18 385:19,21 386:11 milliliters 339:3,17 339:24 mind 339:20 mine 400:12 minor 425:11 minute 386:22,23 433:17 Mischaracterizes 418:6 miscommunication 425:11
---	--	--	---	--

mislabel 346:7	N 336:1	nonresponsive	343:13 351:22	page 336:5 338:10
mislabeled 346:8	name 346:11 375:7	421:8	352:8 355:7	339:12 340:9
346:10	names 400:17	non-event 368:8	357:18 364:23	343:16 345:12
misrepresentations	407:10	normal 394:24	365:8 371:12	351:23 355:7
417:24	Narbone 334:7	normally 381:3	373:1,18 382:2	359:7,14 360:12
misrepresentative	401:23 402:21	406:14	383:15 387:3	371:11 372:17,24
402:24 403:13	405:2 406:3	NORTHERN	396:17 404:8	387:1 389:6,8
404:9 405:3 407:6	408:18 410:9,22	334:1 435:1	411:22 434:13	396:20 400:2
misrepresented	411:16 415:15	Notary 435:20	old 391:10	401:22 410:18
403:6,8	416:1,2,7,10	note 356:18 398:22	once 358:4,15	411:21
missed 343:22	narcotic 391:8	noted 390:15	405:16,21 406:2	pages 338:11 344:8
364:21	narcotics 391:11	notes 375:16 389:7	406:19 420:1	435:7
missing 364:14	narrative 340:20	436:10	ones 345:2 399:14	paid 422:16 427:8
390:15	341:1,13,16	notice 334:14	one-month 431:21	427:18,23 428:11
mistake 409:11,24	nasal 389:12,20	noticed 372:11	one-on-one 422:13	428:18,21 431:22
410:5	nature 366:12	390:6	424:12 426:6	pair 405:9
mistakes 349:16	near 411:23	NP 428:7	ooOoo 434:19	paired 386:20
420:13	necessarily 342:18	number 337:13	op 381:21	405:4,8,14 416:8
misunderstanding	342:19 359:2	344:22 345:3	open 434:5	pairing 386:22
385:7	need 414:14 429:14	351:20 369:24	operate 358:10	pair-ups 405:10
ml 347:16,18	434:4	372:21 393:23	operating 351:6,11	pale 389:10,12
modes 354:15	needed 368:3	401:19 411:23	opinion 396:9	paragraph 338:18
modifications	385:11 430:1	416:2	opponent 414:4	341:21 344:3
345:1	433:11,11	nurse 349:13 350:7	opportunities	345:15 346:3
modify 354:21	needs 349:6 367:20	350:17,19,21,22	377:19 414:10	370:8 371:21
Monday 334:19	386:17 404:22	382:17	opposed 402:5	373:3 375:16
money 422:16	negative 381:11,13	Nursing 431:10	413:5	394:14 396:20
423:4 424:1	406:18 413:23		opposition 414:5	400:3 402:20
monitor 387:17	418:11,14 419:23	O	optional 346:20	410:18
month 423:15	negatively 417:13	Oak 432:8	order 413:6	Paragraphs 412:4
426:20 427:2,11	negatives 408:11	oath 337:3	organized 431:13	parameters 354:17
431:19	neglected 412:15	OB 374:1,9,23	orientation 424:23	paraphrasing
months 378:6	Neptune 349:3	object 393:5	original 432:5	410:3,16
414:17 425:23	nervous 342:6,10	Objection 402:7	Oskvarek 367:7,8	parentheses 389:8
morning 381:5	342:12,16,19,20	objectively 416:5	368:13	Park 432:9
mouth 391:24	342:23 343:2	observation 342:17	outside 411:1 429:2	part 340:17 342:24
417:4	networks 432:12	observed 349:13	outstanding 338:1	377:3 382:7
move 394:18	Neuropack 383:21	obviously 358:6	overall 424:4	398:18 402:10
moving 392:4	never 350:19,19	October 407:8	overheard 391:24	404:6,20 422:8
395:1 408:11	362:14 373:20	408:23 410:10	overlapping 374:7	424:7,9,10 425:8
multiple 345:1	375:5,9 379:20,22	416:14	oxygen 389:13	426:15 427:9
358:9 408:11	379:24 424:9	odd 381:3	o'clock 334:20	428:16,18 429:3
414:10 415:23	425:21 428:23	offer 414:10	398:19,20	430:9
421:3	new 356:2 409:11	offered 397:10	O2 389:20	partial 364:10
	night 429:5	398:8 424:21		partially 346:4
N	nineties 389:13,21	okay 340:8 341:12	P	366:11

participate 382:10	percent 388:7	point 351:8 353:22	388:24	412:3 415:20
particular 353:9,11	432:11	357:11,15,24	present 335:14	416:4 422:3,9,14
382:11 388:22	perform 414:3	363:23 364:21	398:13	422:17 424:4
400:6 429:5	performance 338:4	368:21 374:7,21	presentations	425:8 427:17
particularly 390:3	367:9 405:1	374:23 375:3	426:4,5	430:6,14,17
partly 424:5,5	425:17	396:1 398:24	presented 405:5	431:23 432:23
parts 344:9 348:24	performed 413:22	414:9 424:6	pressure 348:7	433:15
pass 428:5,8,22	performing 367:14	pointed 358:24	354:20,20 382:3	progress 402:22
432:19	420:10	pointing 353:9	383:14 406:16	411:11 433:11
patchy 389:11,12	period 357:7 385:2	413:5,20	prevent 369:14	promised 431:22
patient 345:22	385:10 397:22	poll 408:23 409:3	previous 339:20	prompted 357:14
347:9 348:1,3	399:18	portion 347:4	417:16	386:17
349:16 351:9	persists 414:2,2	357:3 409:20	previously 337:3	proper 340:22
352:14 354:11	person 391:11	430:14	337:11 370:20	341:11
356:20 357:2	403:17,19 408:7	posing 416:19	371:5	properly 349:14
361:24 364:11	409:11	position 424:21	primary 426:9	Propofol 355:11,12
367:17,18,19	personal 416:24	positive 413:21	primed 357:1	355:21,23 356:16
371:17 372:6	personally 431:4	418:15	printing 349:15	356:19 357:1,9,12
375:21 376:3	perspective 396:4	possible 357:17	prior 390:17	388:13,23 392:7
379:12 382:19	pertain 378:16	368:16 371:1	prioritizing 352:10	392:10,13,17
383:3 385:15	pertaining 334:16	379:18	priority 383:5	393:2,9,11 394:18
386:1 388:6,11	PETER 335:11	possibly 359:6	probably 354:4	395:1 396:3
389:2,5,10,12,18	peter.land@husc...	373:17 396:18	361:10 378:3	prospect 342:17
389:24 390:2,10	335:9	potential 396:4	397:24 419:24	prostaglandin
390:14,17,20,21	phone 344:8	potentially 383:10	423:11 426:23	374:12,14,24
391:15,19,23	physical 421:14	383:11 392:3,3	429:17,20	proved 413:24
392:4,12 393:3	pick 389:22	Power 374:20,23	problem 405:6	proven 417:22
394:17 395:1,21	picture 361:7,11,20	375:2	418:21 419:9	provide 426:11
396:3,22 397:4	362:14,18 363:6	practice 388:21	problematic 339:7	provided 419:18
429:4,18	363:11,13 364:10	practicing 424:6	405:5 406:9	provider 389:9
patients 362:3	pictures 364:13,20	practitioner 391:6	problems 352:10	provision 424:7
382:23 429:11	Pitocin 373:14	396:5	396:4 420:7 421:1	Prygodska 337:22
patient's 347:8	placed 352:13	prejudice 417:18	421:4,21	psychiatrist 400:16
352:19 375:19	plain 350:20	prejudices 417:22	procedure 334:15	Psychomotor
389:15 392:22,23	plaintiff 334:4	preoperative 365:7	348:16 379:16	338:17
397:1,2	335:6 403:1,1	preop'd 367:17	382:11,15 386:3	Public 435:20
pattern 408:5	434:11	prep 382:20	386:21 390:4	pulled 348:4
payment 423:4	plaintiff's 402:22	preparation 429:9	396:15 415:11	pump 392:11 395:2
pediatric 384:24	410:23 412:3	prepare 347:21	420:11,19	pumping 350:15
385:7,12 386:1,5	434:6	429:12	proceeded 388:11	purpose 374:5
386:6	plan 429:12	prepared 338:11	388:12	426:8 434:5
peds 385:9	plans 398:6	348:11 382:9,10	process 356:13	pursuant 334:14,14
people 400:11	Plaza 334:18 335:8	389:2,5 397:17	393:6 395:7 433:7	pursuing 417:12
402:17	please 363:15	398:14	program 366:13,21	pushing 420:9
perceive 342:13	409:19	preparing 382:21	378:11 402:23	put 390:14 393:14
perceived 416:23	pocket 391:14	prepping 387:21	410:24 411:11	393:17 397:22

413:4 414:17 419:23 421:24 puts 349:3 putting 417:24 429:18 P.C 335:3 p.m 334:20	372:22 399:17 401:3,7 Ray 334:7 405:2 406:3 410:9 411:16 416:1,2,10 418:12 reach 362:7 reached 395:2 read 341:2,17 365:18 367:12 373:11 375:16 384:24 396:24 397:11 409:21 435:5 reads 389:19 ready 384:2 realized 357:4,13 389:24 390:15 391:4 really 353:7 359:23 362:14 363:12 364:10 368:7 369:1 392:24 397:5 402:14 404:23,24,24 406:23 412:11,12 417:23 425:4,5,13 reason 408:12 434:3 reasoning 344:6 356:13 reassured 407:16 rebuttal 341:12,20 343:11,12,19,24 344:22 351:21 352:4,7 359:19 360:5 364:2,17,18 364:22 397:6,17 399:24 rebuttals 337:16 397:15 398:9,12 399:22 recall 338:4,5 342:21 343:3,21 343:22 344:1,2,5 344:14,17 352:5	353:2,6 354:22 357:7,13,14 358:17 359:23 360:2,6 366:3 368:15 373:17 374:11 376:8,21 377:3,21 379:17 381:5 383:18 385:23 386:19,21 386:23 391:18,18 398:1,10 401:2 404:7 408:3 410:3 410:9 423:8 427:21 receive 423:7,24 428:1 received 344:18 352:6 399:12 401:3 405:13 423:1,4 428:5 receiving 422:19,22 recess 401:14 433:21 recognize 352:18 354:5 356:19 361:3 362:24 370:1 371:24 393:23 recognizing 353:11 recollection 339:19 344:10 356:24 365:22 373:24 378:22,23 379:18 395:11 record 354:4,6 355:1,6 389:24 390:1,13 401:8 409:21 412:23 434:1 recording 355:5 recordings 434:8 434:10,12 records 354:13 399:3 reference 338:21 340:11 345:18,21	351:24 359:15,16 371:17 387:16 referencing 371:4 referring 340:14 341:18 386:8 394:11 400:20 refers 370:12 reflective 404:24 reflex 366:10 refuse 406:11 regardless 427:13 relate 423:17,20 relation 343:23 412:2 relationship 411:2 reliable 386:16 relied 396:20 relieve 347:10 rely 368:18 remainder 361:16 391:8 remaining 427:18 remarks 407:10 remediation 414:13 remedy 350:11 remember 337:16 343:3 344:24 348:23,24 352:6 353:5,8,13,18,20 353:21,24 354:2,7 358:15 360:4,5,11 366:15,16 374:5 376:13,14 377:1 377:19 378:24 379:20 380:17,20 381:5 382:13 384:18 390:2 391:23 404:5,6 415:24 428:15 430:20 reminded 371:7 removal 410:24 412:3 Renee 337:22 repeat 363:14 repetitively 357:20	358:3 reported 334:23 436:7 reporter 436:6,17 represented 420:13 representing 402:9 402:11 reprimanded 371:5 371:8 request 370:16 requested 388:9 409:20 required 388:10,11 reserve 434:11 residency 422:24 423:9 424:3,8 425:18 426:3,7 427:9 428:2,6,8 428:16 430:7,17 431:13 432:20 resident 339:22 340:3 resolve 434:4 respect 354:7 402:24 403:14,15 433:14 respiratory 383:11 383:12 response 344:12 364:20 386:15 393:6 responses 337:14 411:20 rest 361:14 restart 425:20 retirement 424:23 430:8 return 369:5 407:13,19 408:24 416:6 returned 398:5,17 review 399:4,11 411:13 434:8 Reviewing 354:6 re-dose 339:3 394:17
Q				
question 339:14 363:14 364:1 370:22 382:11 393:1,7 406:3 409:18 417:8 425:4 questioning 416:19 questions 365:9,21 365:23 366:2,5,14 366:17 377:2,11 377:12,15 378:20 417:5,8 433:18 434:2 quick 355:23 356:15 358:2 379:14 401:13 quickly 385:12 389:23 quite 372:21 quizzing 373:9 378:18 379:2				
R				
raise 392:13 range 396:6,8 ranked 381:7 rate 337:24 346:24 360:18 367:9 375:19 376:4 394:19 rated 338:5,18 343:9 345:15 348:19 380:11 387:10 ratings 343:19 351:16 359:12 365:4 371:19				

re-dosing 340:4 re-evaluation 337:24 right 338:15,19,24 339:11 340:4,15 341:2,13,18,24 342:7 343:9 345:16 346:11,15 347:23 348:5,9,10 348:10,11,20 351:18 352:1 353:10 359:9,12 359:17 363:6 364:5 365:1 370:17 372:7,10 372:22 378:4,7 379:19 380:4 381:18,22 382:15 386:10 387:11 390:18,22 392:6 394:21 395:4,15 396:9 401:4,11 404:3,16 405:14 405:17,24 407:10 408:3 409:15 410:15 414:12 415:24 417:23 418:5 421:23 422:3,6,14 424:1 424:10 426:14,17 427:2,5 428:6 430:3 431:17 432:2,20,23 433:15 434:11 right-hand 400:4 rising 348:7 risk 379:15 Riverside 334:18 335:8 robot 349:11 350:6 robotic 351:6,8 Rodzick 365:1 372:18 401:2 role 426:8 room 367:19 368:6 368:10 382:20	rotated 432:10 rotational 425:18 roughly 423:16 432:11 route 373:4,12,15 ruin 362:7 ruined 361:13,23 Rules 334:15 running 357:12 392:7 ruptured 382:6,17 382:24 383:4,10 383:20 Rush 334:6 337:19 343:6 344:23 345:4 348:13 351:12 359:7 360:12 363:24 364:23 367:2 371:11 372:17,17 380:2 384:13 387:1,14 400:6,9 402:5,9,22 410:24 411:2,3 413:15 422:16,20 423:4 428:11 431:4,23 432:2,5,7,10,11 432:13,16 433:2 rushed 388:13	399:17 414:6 saying 341:1,15 350:24 353:19,19 356:1 362:19,21 363:8,17 371:2 372:9 375:5,9,13 378:9,12 382:8,9 388:7 395:10 399:1 409:23 418:20 419:9 425:5 says 340:20 341:12 341:16 349:6,10 355:3,8 357:19 358:18 362:23 363:2,3 366:5 374:14 376:15 377:4,9 382:2 387:17 389:10 390:22 394:4 396:20 scan 389:23 schedule 399:7,7 scheduling 411:17 scope 411:1 screaming 420:10 scrutinized 408:15 scrutiny 342:20 414:8 second 345:12 355:7 357:4 366:12 367:17,19 372:24 373:2 386:8 389:6,8 400:2,3 401:20 secretions 361:22 362:4,10 section 340:17,21 341:16,17 354:15 365:7 386:6 401:10 securing 383:5 sedating 391:21 sedation 388:8 see 339:7 340:12,18 343:13,14,17	345:24 349:5 351:24 352:10,14 352:23 356:20,21 359:15,15 362:18 365:10 384:10 386:15 392:5 393:17 394:15 395:14 401:24 403:3 411:3 412:4 433:18 seeking 396:2 seen 368:17 sees 420:1 selected 432:2 self 412:2 self-interest 412:8 412:8,18 413:3 415:2,13,22 417:12,22 self-interests 411:1 sense 408:22 sent 370:3 394:8 406:12 sentence 357:18 373:11 400:3 sentences 349:6 series 370:1 serious 379:4 Seriously 402:18 SERVICES 334:23 session 342:10 401:21 404:3 422:11 set 339:20 359:24 364:13,15 372:14 385:11 407:12 sets 421:3 setting 354:16 385:2,9 387:14 setup 338:6 361:12 361:16 384:1,1 share 398:9 sheet 375:3 Sheila 359:8,16,19 Sherwin 415:7 she'll 369:17	short 385:2,10 shorthand 436:7,10 436:17 shortly 350:17 short-term 396:13 show 354:13 358:19 361:14,16 361:17 363:10 364:10 showed 362:15 417:18 showing 361:20 shows 354:15 413:14 sick 389:18 390:3 side 350:8 400:4 SIEGEL 335:3,5 339:10,12 363:14 380:6 387:5 393:5 402:7,12,15 409:4 409:17 412:10,12 413:16 415:4 418:6,22 419:1,4 421:7,11 424:16 433:19 434:13 siegeledlaw@aol.... 335:4 signed 424:20 signs 394:23 431:3 sim 415:5,6 similar 413:9 simulation 415:11 single 386:3,9 414:6 sites 432:9 situation 342:18 347:24 349:22 389:23 situations 377:19 six 356:1,6 size 395:24 Skills 338:17 Skokie 432:8 sleepy 356:20 slight 347:7 slow 385:9
---	--	--	--	---

snipping 351:8	423:9	377:18 388:3	sure 343:20 345:1	362:17 365:10
soft 385:14	started 347:22	389:2,5 391:7	352:5 353:15,17	393:1 400:9,22
somebody 350:11	366:1 368:7	403:17 414:4,12	355:21 356:10,12	403:18 409:4
396:6,8	380:17 382:22	416:19 417:5,17	358:14 365:23	419:7 420:5 421:9
soon 398:5	384:2 407:9 421:4	425:2 430:9,10	366:18 372:13	talks 365:7
sorry 370:6,22	421:16 422:23	433:14	375:18 377:1	tape-recording
409:5	423:6	students 400:18,23	379:21 381:1	434:4
sort 373:2 408:14	startle 351:10	413:9 417:19,20	383:8 391:7 392:6	tapped 351:9
sought 369:16	starts 373:3 374:10	420:15	392:15 393:14	teach 359:2
434:6	state 411:24 436:1	studied 429:20	406:10 408:3	team 386:17 420:16
spasm 376:4	statement 339:15	study 429:1,4,6,7	417:2,14 418:8	tell 349:12,24 350:9
spasming 379:14	371:21	429:12,13	422:23 423:1	350:21 351:1,5
speak 349:7	statements 346:2	studying 429:9,17	433:6	355:19,22 359:5
speaking 380:15	states 334:1,15	subjecting 403:1	surgeon 350:5	363:2 367:19
specific 423:14	339:2 352:9	407:7	351:6	376:6 388:20
speculate 402:12	388:13 435:1	subjects 366:20	surgical 420:16	389:1 396:24
speculation 402:16	stating 416:4	submit 410:6	switch 354:19	412:7 414:15
spend 423:23 429:8	stayed 422:12	submitted 344:21	358:2	416:16 429:24
429:17	staying 356:16	345:2	sworn 337:3 435:17	telling 415:7
spent 423:18,20	steadily 348:7	SUBSCRIBED	symptoms 421:14	tells 347:14
428:2	stellar 370:9	435:17	syringe 345:19	term 431:14
sphere 400:5	stemming 421:19	suction 360:22	346:10,15 347:1	terms 374:2 385:13
spine 386:3,9	stepped 350:8	361:1 362:23	347:12,13,21	Terrebessy 400:16
spiraled 408:6	sterile 349:7,11,22	363:9,19,20	355:12,21 356:8	410:8,15
spoken 385:14	sticker 346:19	364:11,15	356:11,12 357:1	testified 337:4
spread 403:20	348:9	suctioning 361:22	371:23 372:6	393:6 404:2
spring 428:9	stipend 422:19	suddenly 408:10	390:14,16,23	422:11
squirming 391:23	423:1,3 426:19	suggested 340:3	syringes 372:2,3	testimony 418:7
SRNA 411:11	427:11 430:6,16	suing 402:17	391:14	419:19 436:7
422:2,9 424:22	stop 357:19 358:8	suite 334:18 335:3	system 361:23	text 374:23
430:6	358:11,19,24	335:8 350:23	362:1,7,11 432:11	textbooks 396:10
SRNAs 404:21	359:3 379:13	382:16		texted 405:7
411:17	409:8	supervision 422:13	T	text'd 399:1
SS 435:1 436:1	stopped 365:14,16	424:13 426:7	take 401:13 427:15	thing 346:12
stable 383:8 394:23	365:16 392:8	support 354:20	431:19 433:17	383:18
staff 416:22,23	398:22	412:15 413:12	taken 334:17	things 360:2 376:12
420:15	straight 392:24	414:9,13 415:19	362:20,21 363:6	377:20,21,24
stage 425:18	stress 367:15	416:21	418:13 435:6	393:1,8 408:6
stamp 361:11	stresses 421:15	supported 404:17	436:10	412:14 415:23
362:14,18,18	stressful 342:6	supporting 411:24	talk 353:7 381:9	417:15 421:9,18
standard 425:17	strikes 419:17	supportive 414:7	384:6,9 429:12	425:15 429:14
standing 415:6	stripped 361:19	418:15	talked 368:5 375:2	think 339:19
start 382:21 385:18	struck 381:2	supposed 341:8	393:8 398:6	343:24 344:9,16
386:13 387:19,20	struggled 385:1	391:5,6 398:4	400:11 404:3	344:24 345:7
389:7 414:19	student 361:3	407:12 433:8	406:13,20 420:4	346:24 347:3
422:19,22,24	362:24 367:14,21	suppress 383:10	talking 354:5	349:14 350:7

351:4 352:21 354:3 356:14,24 357:3,10 359:21 359:23 360:8 363:4 364:8,19 365:22 366:9 368:5 372:3 373:15,23 374:1 376:8,18 377:13 378:2 382:6 383:15,19 385:4,6 385:8,16,20,21 386:3,7,20 387:21 388:23 391:22 393:13,15 396:16 398:2,24 401:2,6 404:6 405:9 406:8 407:24 408:9,19 410:12 411:20 412:18 413:2,14 414:14 415:1,12 415:23 416:3,10 417:22 418:21 421:23 422:11 423:8,16 425:1,16 426:20,21 427:12 427:21,23 428:4,7 428:16 430:9 431:5,6,11 432:8 432:15 434:7 thinking 339:19 343:23 374:12 392:17,20 395:12 395:13 thinks 383:19 414:14 415:8 third 383:15 thought 347:17 356:13 374:8 376:6 384:4 386:4 391:16 393:2,6,10 395:7 416:14 425:5,6 three 338:11 344:8 367:10,22 368:13 369:6 383:23	406:1,2 thrown 345:7 tidal 375:19 376:5 time 337:12 344:5 344:21 351:1 357:6 361:11 362:14,17,18 367:14 369:7 375:12 378:3 379:15 380:24 384:21 385:2,2,10 388:14 390:5 394:23 397:6,22 398:8 399:18 400:10 406:12,15 413:18 414:7 422:12 423:18 427:15 428:2,12 429:2,8 430:22 times 358:9 367:22 368:13,15,24 378:12 398:18,21 406:1 418:10,18 today 399:2,15 434:3,3 told 339:19 346:6 348:1 356:12 373:6,14 382:15 382:17 385:3,20 386:10 388:8 390:13 391:19 393:14,18 395:15 395:17,20 396:23 397:14 399:2 407:11,11 409:23 412:22 415:15 416:14 431:16,18 top 400:4 415:24 Tortious 401:22 touch 392:8,13 Tower 406:14,15 training 424:5 425:22,23 426:10 transcript 435:5,8 436:10 translation 341:7	treat 390:10 409:9 421:18 treated 408:4,21 416:5 417:17 treating 425:7 treatment 433:13 treatments 421:16 tried 343:24 350:13 392:11 405:9 408:12 410:8 trouble 357:19 417:6,10 420:1 true 340:21 341:2,5 341:6,13,14,16 350:13 357:15 368:12 375:24 377:6 382:8 387:22 391:1 435:8 436:9 try 391:15 414:11 trying 343:13 352:12 353:23 355:1 360:1 363:22 392:19 408:13 415:15 tube 356:7 tubing 355:22 357:1,22,23 tuition 428:11,14 Tumen 431:2,3 turn 337:18 338:10 340:9 345:3,4,12 348:12 351:12 358:6 359:7 360:12 363:24 364:23 367:1 371:10,11 372:17 372:24 380:2 387:1 388:15 389:6 392:11 401:21 411:21 turned 350:3 357:20 358:12 385:15 387:18,22 turning 357:24 359:5 380:17	turnover 355:23 356:16 twice 433:9 two 343:21,23 344:3 348:20 360:19 381:21 383:16,22 386:7 391:13 403:8 419:17 427:23 431:19 two-week 431:21 type 346:8 types 417:19 421:16 typical 388:24 429:16 <hr/> U Uh-huh 367:6 unacceptable 373:6 373:20 unanimously 409:1 understand 339:6 367:16 369:13 384:3 396:21 402:2 425:4 understanding 341:7 369:1 undo 403:1 uneventful 353:7 unfair 346:24 347:3 380:19 unfamiliar 358:11 386:5 unfavorable 409:13 410:1 unfortunately 391:22 unit 367:18 United 334:1,15 435:1 university 334:6 344:16 432:13 unjustifiably 402:22 410:23 unlabeled 371:23	unnecessarily 352:22 353:12 354:8 unnecessary 354:9 unprofessional 402:19 unsatisfactory 345:16 347:1 348:20 351:16 359:11 360:19 365:3 367:10 371:19 372:22 380:11 387:10 399:17 401:3,7 unused 391:10 unusual 406:13 update 377:20 upheld 404:11 urine 349:12 use 358:19,24 364:11 371:8 373:10,13 374:1,4 379:21 393:16 usual 339:5 usually 342:13 356:15 358:2 372:2,14 380:24 386:13,14 391:9 uterine 374:2 uterus 379:13 <hr/> V VA 352:23 353:13 353:14,16,17 354:8 vacation 427:7,12 427:14,18 430:6 vacuum 361:13,23 362:1,7,11 VAE 366:9 vague 360:9 validate 412:16,23 413:6 validity 404:12,23 408:17 412:16 413:11
--	--	---	--	---

value 413:4	397:11 431:17	354:10 364:14	367:22 368:14	418:14 427:3
vary 427:4	warned 417:7	398:4 405:8 424:7	371:14 372:19	431:11 433:4,19
vent 354:2	Warren 359:8,16	434:9	380:23 387:13	year 377:20,22
ventilated 375:21	Warren's 359:20	white 417:17	396:11 405:16,20	408:9 430:23
ventilating 383:9	wasn't 356:12	Wiley 338:12,18	406:1 411:8	yearly 430:18
ventilation 354:16	363:22 365:23	339:15 340:11	426:13,21 427:5	yep 430:20
354:20 355:4	370:9 372:11	342:5,9 343:5	428:24	
ventilator 353:15	373:9,10 374:20	344:6 345:5	working 357:19	\$
353:18	375:15 382:2	371:14 372:9	worried 351:10	\$800 423:16 426:20
verbal 399:24	387:22 389:3	431:18	worse 370:17	427:2,13
verbalized 389:21	392:14 394:5	Wiley's 340:20	worth 404:23	0
verbally 399:23	396:1 397:17	willingly 402:21	wouldn't 358:23	0 425:14
verify 413:8	398:15 399:6	Wimberly 334:8	417:8	1
Versed 388:3,23	405:12 408:7	401:1,24 402:21	write 340:22	1 401:19
vial 347:14 348:5	414:7 425:8 433:6	403:5,14,23 404:4	344:11 346:5,20	1st 372:19
356:2 386:14	waste 391:6	405:13 406:7	354:23 359:19	1:45 334:20
view 350:20 390:9	watching 351:2	407:21,22 410:22	369:17 370:9	10 340:9 343:16
414:9	352:13	416:7,8 417:1,11	381:20 394:1,3	346:18 385:3,19
viewed 409:24	way 345:19 353:6,6	419:6 420:6,24	403:6	385:21
Vinci 349:9,18	357:5,20 358:1	Wimberly's 411:5	writes 381:15	10th 359:9
350:3	359:1,1,5 381:10	wind 433:19	386:16 403:22	10-milligrams
vindictive 417:4	381:13 390:8	wish 370:10	writing 342:15	385:22
violated 419:2	403:19 409:10,13	witness 336:4	346:11 408:7	11 337:15 340:7
vital 394:23	410:1,5 412:9	339:11,13 380:7	420:4	344:11,22 351:20
volume 354:19	420:14	387:6 391:11	written 347:18	359:14 364:3
375:19 376:5	week 374:6,9 375:2	393:5 419:1	397:10,15 398:9	1100 334:18
vote 409:1	399:6 413:19	witnessed 350:10	399:22 410:6	12 337:11,18 341:2
vs 334:5	426:23,24 427:24	350:14 390:24	419:6 420:1	343:6 345:3
	429:1,8,15	403:18	wrong 357:20	348:13 351:12
W	weekday 429:16	witness's 418:6	359:1,5 373:6,8	355:22 359:8
W 335:3	weekend 429:20	word 365:13 366:4	378:23 418:21	360:13 364:24
Wait 388:12	weekends 429:6,13	371:8 376:17	419:9 420:6 421:2	371:10 384:13
waited 367:18	weekly 398:16	words 410:2,14,16	421:21	120 334:18 335:8
waiting 364:19	400:1	work 338:8 347:19	wrote 342:4,7,8	13 338:15 340:12
wall 360:23 363:9	weeks 427:23	359:2,9 360:15	363:18 370:14	341:3 351:23
363:19	431:19	365:4,21 367:4	379:3 381:18	359:14 411:23
want 351:7 369:18	went 339:2 344:10	369:11 372:18	390:12 397:6,9	416:2 434:7
393:10 397:15	351:4 357:6 374:6	380:8 384:23	410:15 420:22	130s 394:24
399:1 401:13	374:22 382:20	405:19 407:5		135 384:13
412:18 415:16,18	424:22 425:15	411:16 414:14	X	136 380:2,6,7
421:5	433:7	416:21 418:1,4,20	X 336:1	14 337:20 360:16
wanted 354:21	weren't 356:10	419:6,8 420:5,24	Y	149 402:20
369:1,16 370:20	364:20 378:19	422:6 423:17	yeah 347:3 352:6	151 410:18 412:4
370:24 383:16	379:7	434:9	353:18 364:19	16 401:7
385:12,17,22	we're 340:15	worked 338:14	375:1 399:23	
392:7,15 393:13	341:17 344:3	345:5 358:8 359:3		

16-cv-06109 334:5	28 432:18	7:00 398:19		
161 412:4	29 387:8 394:3	70 371:11		
18 345:6,10		73 367:2		
19 334:19 435:6	3	74 364:23		
436:9	3 337:13 344:3	76 360:12		
	411:19 416:1	78 359:7		
2	3,000 428:17			
2 340:17 346:5	30 394:19 395:3	8		
347:17 423:23	30-minute 396:15	8:00 398:20		
20 336:18 347:15	312.526.1631	80 351:12 432:11		
347:15,17 348:16	335:10	80s 394:24		
365:1 369:21,24	312.583.9970 335:4	82 348:13		
405:12 406:13	33 401:22	84 345:4		
407:1 427:12	337 336:10 435:7	89 339:13 343:6		
20-milligram	34 410:18			
386:14	369 336:18	9		
2013 378:2,2 385:8	393 336:18	9 370:4		
403:9 410:10		91 337:19		
423:12 426:22	4			
428:6 429:1	40 395:4,23 396:7			
430:24	396:17 423:23			
2014 337:15 338:15	403b 424:24 430:8			
340:12 341:3	430:16			
344:13 345:6,10	405 335:3			
348:16 351:14	42 411:21			
359:9 360:16	434 435:7			
365:1 367:5				
369:11 370:4	5			
371:15 372:19	5 338:24 339:3,3,17			
378:4 380:3,9	339:24 340:4			
384:16 387:8	386:10 406:15			
394:3 398:17	5-milligrams 385:3			
403:10 407:1	50 390:15			
428:9,14 430:24	53 335:3			
432:20	55 387:1,5,6			
2018 334:19 435:6	6			
435:18 436:9	60 426:23,24			
21 336:18 380:3,9	428:24			
393:20,21,23	60604 335:4			
399:22 400:2	60606 335:9			
2200 335:8	68 372:17,17			
24 367:5 388:7	69 372:18			
410:10				
25 351:14 371:15	7			
371:16 390:13	7 406:14			
27 384:16				

EXHIBIT

A19

Deposition of Michael Kremer - March 14, 2018

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IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

MARICEL MARCIAL,)
Plaintiff,)
vs.) No. 16 CV 06109
RUSH UNIVERSITY MEDICAL CENTER;)
DR. MICHAEL KREMER, in his)
individual capacity; RAY)
NARBONE, in his individual)
capacity; and JILL WIMBERLY, in)
her individual capacity;)
Defendants.)

**CERTIFIED
TRANSCRIPT**

The deposition of MICHAEL J.
KREMER, Ph.D., CRNA, CHSE, FNAP, FAAN, called by
the Plaintiff for examination, taken pursuant to
the provisions of the Code of Civil Procedure and
the Rules of the Supreme Court of the State of
Illinois pertaining to the taking of depositions
for the purpose of discovery, taken before JULIE
WALSH, CSR No. 084-004032, a Notary Public within
and for the County of Lake and State of Illinois,
and a Certified Shorthand Reporter of said State,

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 2

1 at 120 South Riverside Plaza, Suite 1100, Chicago,
2 Illinois, on March 16, 2018, at 9:00 o'clock A.M.
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21
22 Reporter: Julie Walsh
23 CSR No. 084-004032
24 APPEARANCES:

Page 3

1 ELAINE K. B. SIEGEL & ASSOCIATES, P.C.
2 BY: MS. ELAINE K. B. SIEGEL
3 53 West Jackson Boulevard, Suite 405
4 Chicago, Illinois, 60604
5 312-583-9970 | 312-583-9972 (fax)
6 Siegel-law.com
7
8 on behalf of the Plaintiff;
9
10 HUSCH BLACKWELL
11 BY: MR. PETER G. LAND
12 MS. KAREN L. COURTHEUX
13 120 South Riverside Plaza, Suite 2200
14 Chicago, Illinois, 60606
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18
19 on behalf of the Defendants.
20
21 ALSO PRESENT: Ms. Maricel Marcial
22 Mr. Joseph Mendelsohn
23
24

Page 4

1 INDEX
2
3 WITNESS EXAMINATION BY PAGE
4
5 Dr. Kremer Ms. Siegel 05
6
7
8
9
10
11
12
13
14 EXHIBITS PAGE
15
16 Plaintiff's Exhibit No. 11, id 48
17 Plaintiff's Exhibit No. 12, id 59
18 Plaintiff's Exhibit No. 13, id 80
19 Plaintiff's Exhibit No. 14, id 167
20
21
22
23
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Page 5

1 (Whereupon the deposition
2 commenced at 9:11 a.m.)
3 MICHAEL J. KREMER, Ph.D., CRNA, CHSE, FNAP, FAAN,
4 witness herein, called by the Plaintiff, having
5 been first duly sworn, was examined and testified
6 as follows:
7 EXAMINATION
8 BY MS. SIEGEL:
9 Q Will you state and spell your full
10 name for the record, please.
11 A Michael John Kremer, K-r-e-m-e-r.
12 Q And, Dr. Kremer, what is your current
13 position?
14 A I'm a professor in the Rush College of
15 Nursing and Co-Director of the Rush Center for
16 Clinical Skills and Simulation.
17 Q Who is your co-director?
18 A Michelle Sergel, M.D.
19 Q All right. Before we go further into
20 your background, you've had your deposition taken
21 before?
22 A I have.
23 Q Under what circumstances?
24 A As a retained expert witness.

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 6

1 Q And when was that?
 2 A Over ten years ago.
 3 Q What kind of matter?
 4 A It was more than one case. I would
 5 say there were about two dozen mix of plaintiff
 6 and defense cases, primarily defense.
 7 Q Okay. And what was the -- just
 8 generally speaking what was the nature of your
 9 testimony?
 10 A Nature of the testimony pertained to
 11 standards of care for nurse anesthesia practice.
 12 Q Are those the only depositions that
 13 you've given?
 14 A Yes, as well as testimony in court.
 15 Q And where have you testified?
 16 A Decatur, Illinois. Here in the city.
 17 Louisville, Kentucky. And in Miami, Florida.
 18 Q And were those state or federal
 19 proceedings?
 20 A I don't know to be certain. How could
 21 I help you with that?
 22 Q All right.
 23 A I'm thinking they were probably state,
 24 but I'm not positive.

Page 7

1 Q Okay. Well, as far as this case is
 2 concerned, we'll let the record reflect that this
 3 is your deposition pursuant to notice. You
 4 received a notice of your deposition?
 5 A Yes, ma'am.
 6 Q All right. In the captioned matter
 7 for all purposes under the Federal Rules of Civil
 8 Procedure.
 9 And now have you had your deposition
 10 taken as a party or a witness as opposed to an
 11 expert?
 12 A I have not.
 13 Q And expert depositions are a little
 14 bit different from what we are going to be doing
 15 today. And so what I am going to be doing is
 16 asking you a series of questions. You'll be
 17 answering. We have the court reporter here who
 18 will take things down verbatim.
 19 And so because we need to have a clear
 20 transcript, it's important that we not talk over
 21 each other. It's important that we have verbal
 22 responses, not simply gestures or nods of the
 23 head or things like that. And it's important
 24 that they be distinguishable. Uh-huh and uh-huh

Page 8

1 don't come across clearly in the record as
 2 affirmative or negative responses. Do you
 3 understand that?
 4 A Yes, ma'am. Can I clarify something?
 5 Q Surely.
 6 A On a previous question?
 7 Q Surely.
 8 A When you asked if I had been deposed
 9 as a party, I remembered after responding that in
 10 I would say it was around 1996 there was a
 11 clinical case at Rush in which I was not a named
 12 defendant, but my deposition was taken.
 13 Q Okay. And, again, you don't know
 14 whether that was state or federal court?
 15 A No, I don't.
 16 Q Okay. Did you ever have a case go to
 17 trial that you were in?
 18 A As a retained expert?
 19 Q Yes.
 20 A Four that I can remember.
 21 Q All right. Now, from time to time,
 22 little differently from being in court, your
 23 counsel may make objections. That gives me the
 24 opportunity to cure the form of the question that

Page 9

1 I give you, but you are expected to answer.
 2 Should you be directed not to answer
 3 by your counsel, that's another story. But
 4 obviously we don't have a judge sitting here. So
 5 there is nobody to rule on the -- rule on the
 6 objections. So they go on the record to be
 7 resolved at a later date if that may be done.
 8 Okay. If you would like to take a
 9 break at any time, just let us know. We are glad
 10 to accommodate you. But if there is a pending
 11 question, please respond to the question before
 12 seeking to take a break.
 13 A Yes, ma'am.
 14 Q Is that fair? All right. Now, and we
 15 ask this of everybody; is there any kind of
 16 medication that you are taking or do you have any
 17 medical condition that would prevent you from
 18 responding accurately to the questions?
 19 A Do I have to answer that, what
 20 medications I'm taking?
 21 Q I'm not asking you what medications
 22 you're taking. I am asking you if you are taking
 23 any medications or have a medical condition that
 24 would prevent you from answering accurately to

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 10

Page 11

1 the questions that I'll be posing?
 2 A No.
 3 Q What did you do to prepare for your
 4 deposition?
 5 A Reviewed the student's file and any
 6 other documents, internal documents, that were
 7 prepared related to her academic appeal and
 8 accreditation complaint.
 9 Q Did you look at anything else?
 10 A No.
 11 Q Apart from your counsel did you confer
 12 with anybody regarding your deposition testimony?
 13 A I did not.
 14 Q Did you talk to anybody about any
 15 testimony that they've given in this matter?
 16 A I did not.
 17 Q Did you look at any other kinds of
 18 documents?
 19 A I did not.
 20 Q No litigation documents?
 21 A Well, the complaint and the responses.
 22 I can't remember the name of that document.
 23 Q The answer to the complaint?
 24 A Yes.

1 Q Affirmative defenses?
 2 A I'm not sure if that is the name of
 3 the document.
 4 Q Did you look at interrogatory
 5 responses?
 6 A Yes.
 7 Q Anything else?
 8 A No.
 9 Q Did you review any deposition
 10 transcripts?
 11 A No.
 12 MS. SIEGEL: Can we go off the record for a
 13 moment?
 14 (Discussion outside the
 15 record.)
 16 BY MS. SIEGEL:
 17 Q Would you summarize for us,
 18 Dr. Kremer, your educational background?
 19 A I have a Bachelor's Degree in
 20 Psychology from Northern Illinois University that
 21 I obtained in 1975. Bachelor's Degree in Nursing
 22 from Northern Illinois University that I obtained
 23 in 1978.
 24 I earned a certificate in nurse

Page 12

Page 13

1 anesthesia from St. John's Hospital in
 2 Springfield, Illinois, in 1981 along with a
 3 Bachelor of Science in Nurse Anesthesia from the
 4 University of Illinois in 1981.
 5 I earned a Master's of Science in
 6 Nursing from Seattle Pacific University in 1991
 7 and I completed my Ph.D. in Nursing Science at
 8 Rush University in 1997. And in 1998 and 1999 I
 9 completed a post-doctoral research fellowship.
 10 Q And where did you do your post doc?
 11 A At Rush.
 12 Q Would you summarize for us, please,
 13 your nursing career?
 14 A Following graduation from nursing
 15 school in 1978 I worked on the medical intensive
 16 care unit at the time it was Presbyterian St.
 17 Luke's Hospital. And following that experience I
 18 moved to Springfield and started the anesthesia
 19 program at St. John's, and I worked part-time in
 20 the emergency department at St. John's throughout
 21 my education which is a level-one trauma center.
 22 Following completion of anesthesia
 23 school in 1981, I moved to Seattle. I worked for
 24 2 years at Swedish Hospital Medical Center. It's

1 a large private medical center as a staff nurse
 2 anesthetist.
 3 From 1983 until 1992 I worked at the
 4 University of Washington Medical Center as a
 5 teaching associate and staff nurse anesthetist
 6 and later chief nurse anesthetist.
 7 Moved back to the Chicago area at the
 8 end of 1993 and worked for the Rush Department of
 9 Anesthesia as a staff CRNA and as a teaching
 10 assistant in the College of Nursing from 1993
 11 until 1997 when I finished my doctorate and then
 12 was an assistant professor, continued working at
 13 Rush as a staff CRNA, Co-Director of the
 14 Simulation Center and instructor and later
 15 Assistant Director of the Nurse Anesthesia
 16 program through 2005.
 17 From 2006 through 2009 I was Chair of
 18 the Nurse Anesthesia Department in the College of
 19 Health Professions at Rosalind Franklin
 20 University in North Chicago, Illinois.
 21 And since 2009 I've been at Rush as --
 22 I was Program Director from 2009 until the end of
 23 2017 and Co-Director of the Sim Center and a
 24 part-time CRNA.

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 14

1 Q And as Co-Director of the Sim Center,
2 what do you do?
3 A Oversee budget and HR matters. The
4 Sim Center is rapidly expanding from the much
5 smaller space we had when Maricel was in school.
6 Now we're -- by July we'll be in a
7 20,000-square-foot space with a lot of different
8 programming going on over 10 staff.
9 So I'm involved in the site's budget
10 and HR and overseeing getting the lab accredited.
11 There are 2 different bodies that we're working
12 toward accreditation with and involved in some
13 research projects in the Sim Center too.
14 Q What kind of research projects?
15 A The most recent one that I think is
16 really interesting that has to do with safety and
17 quality in the operating room has to do with a
18 scenario that surgery residents, OR nurses and
19 anesthesia providers, participate in where there
20 is a crisis in the middle of laparoscopic
21 gallbladder surgery.
22 And the object of -- what we are
23 measuring in the scenario is reaction time and
24 time to communicate and ask for help. And we

Page 15

1 have pilot data and we have some significant
2 findings with that.
3 Q So do I understand that you're
4 identifying factors that relate to reaction time?
5 A Yes, ma'am.
6 Q And communications among the personnel
7 that would be attending the procedure that's
8 being simulated in the lab?
9 A Correct.
10 Q Is that document in publication?
11 A There is a manuscript draft in
12 progress and it's being submitted to the Journal
13 of Surgery.
14 Q Is that refereed?
15 A Yes, it's peer reviewed.
16 Q Okay. And do you have other
17 publications?
18 A I do.
19 Q Can you tell us a little about them,
20 please?
21 A So I authored or coauthored a number
22 of journal articles and peer-reviewed
23 publications on a variety of topics both
24 educational and clinically related, and authored

Page 16

1 or coauthored book chapters and abstracts as
2 well.
3 Q In the -- you talked about some cases
4 in which you appeared as an expert witness, were
5 you qualified as an expert by the court in any of
6 those cases?
7 A I'm not sure what that process
8 entails. I was allowed to testify as an expert.
9 Q In the four cases that went to trial?
10 A What about the four cases that went to
11 trial?
12 Q You testified as an expert in those
13 four cases?
14 A I did.
15 Q And with respect to your current
16 research, what did -- what are you finding are
17 factors that contribute to communication around
18 the crisis procedure that you're discussing?
19 A What we're finding is that the
20 participants can formulate differential
21 diagnosis, arrive at the correct diagnosis which
22 is tension pneumothorax and develop a treatment
23 plan which is the decompression of the tension
24 pneumothorax all very quickly.

Page 17

1 What we're not seeing that we're
2 trying to educate people on when they debrief
3 after the scenario is that they are not calling
4 for help. They're not -- since it's trainees
5 participating in the project, we want them to
6 know that, you know, they should be calling their
7 attending surgeon, attending anesthesiologist and
8 for everybody in the room conveying that
9 everybody should be able to speak up if they have
10 a safety concern.
11 Q And has your research on this crisis
12 procedure, has your research attempted to
13 identify factors that are inhibiting that type of
14 communication?
15 A The data are being analyzed as we
16 speak, so I couldn't say for sure.
17 Q Do you have a hypothesis?
18 A I think hierarchical relationships
19 could contribute.
20 Q What is a hierarchical relationship?
21 A Well, the trainees -- actually, I was
22 thinking trainees might be inhibited about
23 letting their attendings know that there is an
24 issue, but the more I think about it is more of a

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 18

1 case of that they are rapidly acting to diagnose
2 and treat the problem that they've identified.
3 And I think because they're caught up in getting
4 the patient stabilized, they don't think to let
5 others know what is happening.
6 Q And are you doing something in this
7 capacity in order to test that hypothesis? It
8 sounds like you have two alternative explanations
9 in play; is that right?
10 A Yeah, I'm not the principal
11 investigator; but, you know, I think the data
12 will confirm or refute the hypotheses that she's
13 formulated.
14 Q Okay. And you said that you're
15 working as a part-time CRNA at the same time?
16 A Until a year-and-a-half ago. And then
17 I haven't practiced for a year-and-a-half.
18 Q And why did you change positions from
19 -- just to --
20 A I'm sorry.
21 Q Just to clarify what we're talking
22 about here, why did you change positions from
23 your prior program director position in the nurse
24 anesthesia program?

Page 20

1 A Some people will use that terminology.
2 They're equally applicable or nursing anesthesia
3 program.
4 Q Okay. What were your duties?
5 A To keep the program in compliance with
6 accreditation standards, to assign faculty
7 workload, to insure that we had adequate clinical
8 placements for our students and to engage in
9 continuous quality improvement processes for the
10 program.
11 Q And what did the quality improvement
12 processes consist of; what were the primary ones?
13 And let's specify time period here. Let's say
14 2012 through the balance of the time that you
15 were program director?
16 A So, yeah, the quality improvement
17 activities really stemmed from the college.
18 Nursing has an evaluation plan that is pretty
19 extensive at the program level.
20 We monitor on the student side
21 formative clinical evaluations, student progress.
22 But then on the other side of things students
23 complete a number of evaluations during the
24 program and following completion of the program.

Page 19

1 A I had been requesting that change for
2 several years partly for health reasons and
3 partly advancing age. I'll be 65 this year. I
4 would like to be working less than 70 hours a
5 week and 7 days a week.
6 Q And just for the record, what is your
7 birth date?
8 A August 17, 1953.
9 Q And you are Caucasian; is that
10 correct?
11 A Yes, ma'am.
12 Q What is your national origin?
13 A My mother was -- my mother's family
14 came from Italy. My father's family came from
15 Germany.
16 Q They were both first generation?
17 A Mother was first generation. Father
18 was second generation.
19 Q Now, during the time that you were
20 director of the nurse anesthesia program at Rush
21 -- for simplicity can we refer to that as a CRNA
22 program; is that the correct title?
23 A Yes, ma'am.
24 Q Not the SRNA program?

Page 21

1 So midpoint program surveys, end of program
2 surveys, graduate surveys, employer surveys and
3 use those data to identify any gaps that we can
4 address, you know, in terms of improving quality
5 of the program.
6 Q Who maintains those surveys?
7 A We have a -- well, now it is overseen
8 by somebody at the university level, Dr. Rose
9 Suhaypa who is also a faculty member.
10 Q Could you spell that for the court
11 reporter, please?
12 A Yes, ma'am. It's Rose Marie Suhaypa,
13 S-u-h-a-y-p-a, Ph.D., RN. And she's the
14 Associate Provost for Institutional Research and
15 Accreditation. So she and her staff oversee
16 evaluative processes for all the colleges. And
17 they're the ones who deploy most of the surveys
18 that are utilized that students respond to.
19 Q And I understand we have a group of
20 surveys that are on the way over today?
21 A I'm sure trying.
22 Q All right. I appreciate that. But
23 what is it that we're anticipating?
24 A They're the clinical instructor

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 22

1 evaluations. And those were deployed by our
2 previous program assistant through Survey Monkey.
3 And it's an account I don't have access to. I
4 was able to locate some hard copies yesterday
5 that I brought in this morning, but I have
6 contacted several people in the college and asked
7 for them to urgently download those surveys and
8 forward them to me and I'll get those to counsel.
9 Q Okay. And, again, for the time period
10 of 2012 -- was it -- it was through 2017 that you
11 were director?
12 A 2009 through 2017.
13 Q Okay. Now, for that time period, 2012
14 through 2017, once those surveys were -- Strike
15 that.
16 I know that we have some documents --
17 excuse me. I understand that we have copies of
18 some of these materials coming, but can you tell
19 me what generally you're attempting to measure
20 through the faculty surveys, faculty surveys by
21 the SRNAs?
22 A Yes, so the goal of deploying those
23 surveys and evaluating the results is to identify
24 people who may be performing at a very high level

Page 23

1 as a clinical instructor both nurse anesthetists
2 and anesthesiologists and to identify where there
3 may be room for improvement. And I share those
4 surveys with the clinical leadership. So the
5 attending surveys go to Dr. Tuman, Chair of the
6 Anesthesia Department and the clinical instructor
7 surveys --
8 Q Could you spell Dr. Tuman's name for
9 the court reporter?
10 A Sure. It's Kenneth J. Tuman,
11 T-u-m-a-n, M.D. And then the clinical instructor
12 evaluations for the nurse anesthetists I would
13 share with Ray Narbone.
14 Q And then once Dr. Tuman gets the
15 surveys, do you know what he does with them?
16 A Well, what he told me is that he
17 makes --
18 Q Before you tell me what he's told
19 you --
20 A Yes, ma'am.
21 Q -- can you give me a timeframe that
22 you're referring to?
23 A The timeframe would be after the
24 program assistant would send me the results and I

Page 24

1 review them, print them out and then just
2 schedule time because I had regular meetings with
3 Dr. Tuman. So in our next regular meeting we
4 would review those surveys. And he told me that
5 he made the findings part of the attendings'
6 annual review.
7 Q And, again, when did he tell you this?
8 A At regular meetings we had over the
9 nine years I was program director or eight years.
10 Q Is there a specific time of year that
11 you would typically have those meetings?
12 A Well, we met about every month.
13 Q And did you get those surveys on a
14 rolling basis?
15 A The clinical instructor evaluations?
16 Q Correct.
17 A Once a year.
18 Q All right. And then how about Ray
19 Narbone?
20 A And then I interacted with Mr. Narbone
21 more frequently than I did with Dr. Tuman. So I
22 would probably have a conversation with him on
23 average about once a week. And so it would be in
24 the course in one of those conversations in a

Page 25

1 private location that I would share the clinical
2 instructor evaluations.
3 Q Did you discuss those evaluations with
4 the instructors?
5 A Yes.
6 Q And tell me about how that transpired?
7 A It tended to be -- those discussions
8 with instructors, many of them had to do with
9 people who were getting very high rankings just
10 to let them know that their work was being
11 recognized.
12 If there were instances where a rating
13 or verbatim comment was concerning, then I would
14 talk to that instructor privately and tell them
15 that I had concerns about how they were
16 interacting with students.
17 Q And if you identified concerns with a
18 specific instructor, are we speaking of CRNAs?
19 A Yes, with CRNAs.
20 Q Where concerns were identified, what
21 would be done about that? You talked about how
22 you would share the rating with them, was there
23 any follow-up action?
24 A There were times when I asked Mr.

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 26

Page 27

1 Narbone to minimize the interactions of certain
2 instructors with students, but that was not
3 something I had control over. He usually -- he
4 usually did that, but it was hard to insure that
5 it would happen consistently.

6 Q In the -- and we can perhaps depending
7 on when we get the evaluations how many of them
8 there are, whether we have an opportunity to
9 review them in order to talk with you today about
10 them, can you tell me if there were evaluations
11 raising issues about the instructional work of
12 Jill Wimberly? And she's a CRNA in the Rush
13 program; isn't that right?

14 A That's right.

15 Q Okay.

16 A What I remember in her clinical
17 instructor evaluations were statements that she
18 was very bright. That her communication style
19 could be abrupt, but her overall numerical
20 rankings -- it's only a few items, a few
21 descriptors; but her numerical rankings outranked
22 from those of her peers.

23 Q And at any time did you discuss the
24 communication style with Miss Wimberly?

1 A I did.

2 Q When did that occur?

3 A I remember at least one occasion
4 either before or after a CRNA staff meeting when
5 we talked privately. Actually, and then there
6 was another occasion as well when --

7 Q Let's take them one at a time.

8 A Yes, ma'am.

9 Q So after the CRNA staff meeting -- let
10 me back up a minute.

11 Can you tell us what usually goes on
12 at a CRNA staff meeting?

13 A Well, there are staff meetings and
14 there are faculty meetings. Staff meetings
15 pertain mostly to clinical operations issues.

16 Q Not personnel?

17 A More tangentially people -- when
18 personnel are mentioned, those discussions are
19 more about people who are coming or going in
20 terms of staff. You know, new staff starting or
21 staff who are leaving. But the staff meetings
22 are almost entirely about clinical operations
23 kinds of business.

24 Q Who attends them?

Page 28

Page 29

1 A The nurse anesthetists, the chief
2 nurse anesthetist and now there's another
3 position, anesthesia operations director.

4 Q Who is that?

5 A Her name is Melissa Carey, C-a-r-e-y.

6 Q Okay. And how often did the staff
7 meetings occur?

8 A Roughly monthly, but sometimes there
9 would be longer intervals between those meetings.

10 Q And you mentioned faculty meetings?

11 A Yes, ma'am.

12 Q Tell me about those?

13 A There are at least in my time there
14 were two different kinds of faculty meetings.
15 One was with core academic faculty that focussed
16 primarily on academic issues like assignment of
17 course director responsibilities, lecture
18 responsibilities and now our students have to do
19 a major scholarly project and that involves a lot
20 of work and planning. So those are the kinds of
21 things we talk about at the core faculty meeting.

22 It's harder to get together with the
23 clinical instructors because there are now about
24 30 nurse anesthetists at Rush. So approximately

1 every other month Dr. Wiley and I would meet with
2 the clinical instructors to review -- it's a
3 meeting we've had as long as I've been involved
4 with the program. It's called clinical
5 competence review. Just basically a chance to
6 kind of verify and clarify what is coming back in
7 written evaluations or also determining when
8 supervision can be thinned from one-to-one CRNA
9 supervision to the students working directly with
10 anesthesiologists.

11 Q And is Miss Wimberly a member of the
12 faculty?

13 A Miss Wimberly is a staff nurse
14 anesthetist who is employed by the Department of
15 Anesthesiology. She does not have a faculty
16 appointment in the college of nursing.

17 Q All right. And so after one of these
18 meetings, to the best of your recollection would
19 it have been one of the clinical faculty
20 meetings?

21 A I think it was actually a staff
22 meeting.

23 Q Okay. A staff meeting. All right.

24 And do you recall approximately when that

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 30

1 occurred?
 2 A Probably three years ago.
 3 Q So the spring of 2014?
 4 A Roughly that time, yes.
 5 MR. LAND: Isn't that 4 years ago? It's
 6 2018.
 7 MS. SIEGEL: That's right. I missed a year.
 8 BY MS. SIEGEL:
 9 Q So is it your recollection that that
 10 occurred in 2015 or 2014?
 11 A I can't say for sure.
 12 Q Okay. That's fine. And so where did
 13 this discussion with Miss Wimberly occur?
 14 A In the anesthesia department in an
 15 alcove that's adjacent to a small classroom where
 16 those staff meetings are held.
 17 Q And who was involved in the
 18 discussion?
 19 A Just Miss Wimberly and me.
 20 Q What did you say to her and what did
 21 she say to you?
 22 A To the best of my recollection I was
 23 encouraging her to be cautious in how she spoke
 24 to students. And she indicated, you know, that

Page 31

1 she understood what I was saying. That was about
 2 as far as it went.
 3 Q And as well as you can recall, what
 4 was the -- what was the nature of the evaluation
 5 that prompted that discussion with Miss Wimberly?
 6 A I think a student had been upset about
 7 an encounter that she had had with Jill.
 8 Q Do you remember -- Strike that.
 9 Did you know who the student was who
 10 had the encounter she was upset with?
 11 A I'm -- I think it was a student named
 12 Sarah Curry.
 13 Q Do you recall what cohort she was in?
 14 A She was in our first DNP cohort. So
 15 she completed the program in December of 2015.
 16 Q And what was the nature of Miss
 17 Curry's complaint? Dr. Curry I should say.
 18 A You're right. I think it had to do
 19 with comments that were made about Sarah being
 20 dyslexic.
 21 Q Did Dr. Curry tell you what that
 22 incident consisted of, what happened?
 23 A I believe she did at the time, yes.
 24 Q And when did she tell you about that?

Page 32

1 A Probably the same day.
 2 Q What did she tell you?
 3 A Oh, what did she tell me?
 4 Q Right, just a conversation with the
 5 two of you or was Miss Wimberly involved or
 6 anyone else?
 7 A No, it was the two of us and it had to
 8 do with something that was misspelled on a chart,
 9 and Miss Wimberly being critical about that and
 10 Miss Curry responding that she was dyslexic.
 11 Q Do you know anything more about that
 12 encounter?
 13 A No.
 14 Q And how did you learn about the
 15 encounter?
 16 A From the student.
 17 Q Okay. Did you learn anything from an
 18 evaluation that you received, a student
 19 evaluation about Miss Wimberly?
 20 A Oh, a student evaluation? Like a
 21 clinical instructor evaluation?
 22 Q Right. Right.
 23 A No, I just remember her communication
 24 style being characterized as abrupt, but there

Page 33

1 weren't a lot of verbatim comments on those
 2 clinical instructor evaluations for most of the
 3 instructors.
 4 Q When did that first come to your
 5 attention that she -- that there were student
 6 concerns about her abrupt communication style?
 7 A I really don't recall.
 8 Q Did you ever observe her to see about
 9 her communication style with the SRNAs?
 10 A Yes, a number of different times.
 11 Q How many times?
 12 A I couldn't say for sure how many
 13 times.
 14 Q Did you ever observe it yourself?
 15 A I observed Miss Wimberly communicating
 16 with students, yes.
 17 Q And would you agree that at times her
 18 communication style was abrupt?
 19 A In what I observed infrequently, but I
 20 observed it.
 21 Q What did you see?
 22 A An incident in our interventional
 23 endoscopy area with a student. Had to do with a
 24 preoperative evaluation.

1 Q And were you present there in the
2 interventional endoscopy area?
3 A Yes.
4 Q And what did Miss Wimberly say that
5 you characterized -- that you would characterize
6 as abrupt?
7 A She felt the student hadn't done
8 everything that needed to be done to complete
9 preanesthesia evaluations on that day and was
10 just a bit forceful the way she conveyed that.
11 Q What do you mean by a bit forceful,
12 did she raise her voice?
13 A I think it was probably just more in
14 the words used.
15 Q They were sarcastic?
16 A Along the lines of, you know, you
17 really have to do this or get this right.
18 People, you know, will be on your case if you
19 don't have this right every time.
20 Q Do you recall who the student was?
21 A Hanna Kuna.
22 Q And did Hanna Kuna complain to you
23 about Miss Wimberly's communication style?
24 A I could tell that she was concerned

1 about the communication. We talked briefly
2 privately. And then I talked to Mr. Narbone.
3 Q What did you tell Mr. Narbone?
4 A That I wanted him to minimize her
5 interaction with students.
6 Q Miss Wimberly's interaction with
7 students generally?
8 A Yes.
9 Q And do you recall when that occurred?
10 A The same day that I was also assigned
11 an interventional endoscopy.
12 Q Now, do you remember a timeframe, just
13 as well as you can recall?
14 A I'm just trying to remember which
15 cohort she was in 2013-2014.
16 Q And when did you speak with Mr.
17 Narbone?
18 A Right after I spoke with the student.
19 Q And after you told Mr. Narbone to
20 minimize Miss Wimberly's contact with students,
21 did you follow up to see how those assignments
22 were going?
23 A The short answer is yes. The caveat
24 being that we have up to 72 students in the

1 clinical area at 10 different facilities at the
2 same time. So to the extent that, you know, it's
3 possible to at least intermittently verify that
4 that was happening, and it did appear to for a
5 while after that conversation that she had less
6 contact with students.
7 Q Did her contact with students
8 subsequently increase?
9 A Yes.
10 Q And when did you notice that her
11 contact with students had increased?
12 A I couldn't say for sure.
13 Q Was there an issue regarding Miss
14 Wimberly's contact with the plaintiff, Maricel
15 Marcial?
16 MR. LAND: Could you read that back, please.
17 (Record read by the reporter.)
18 MR. LAND: Just object as vague, but you can
19 answer.
20 THE WITNESS: I know Miss Wimberly worked
21 with Maricel on three different occasions while
22 she was clinically active.
23 BY MS. SIEGEL:
24 Q And did a communications issue come to

1 your attention?
2 A Well, I know the first time they
3 worked together at least that is documented in
4 her student file she received a satisfactory
5 evaluation from Miss Wimberly. And the second
6 occasion there were documented concerns on the
7 evaluation that was submitted.
8 Q That was an evaluation of Miss Marcial
9 by Miss Wimberly; is that right?
10 A Yes, ma'am.
11 Q All right. And by the way, I
12 understand that Miss Wimberly's name has changed.
13 We've been using the name Wimberly for purposes
14 of consistency. Do you -- you know who I mean?
15 A Yes, I saw that in a database that we
16 use for the program. I think she is still using
17 Wimberly at work, but I think her married name is
18 O'Neil if I read that correctly.
19 Q All right. And, now, the evaluation
20 that you're talking about was Miss Wimberly's
21 evaluation of Miss Marcial.
22 When did -- Strike that.
23 When did Miss Wimberly's
24 communications come into issue with Miss Marcial?

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 38

1 A I don't know that there was an issue
2 with her communication with Miss Marcial.
3 Q Did there come a point where you asked
4 Mr. Narbone to minimize Miss Wimberly's contact
5 with Miss Marcial?
6 A Yes, shortly after that June 20th,
7 2013, case.
8 Q And how did you communicate that to
9 Mr. Narbone?
10 A I simply asked him to minimize Jill's
11 interaction with Maricel and he did that.
12 Q What did he say when you asked him to
13 do that?
14 A I don't recall specifically.
15 Q Now, did Mr. Narbone express any
16 opinions to you regarding Miss Wimberly's
17 performance as a CRNA?
18 A What I recall is that he, you know,
19 expressed that she was very clinically
20 proficient.
21 Q Did he comment at any point about Miss
22 Wimberly's teaching abilities?
23 A Not that I recall.
24 Q Now, would you agree with me that

Page 39

1 teaching proficiency is a significant aspect of
2 the CRNA's performance?
3 A I would need a little clarification
4 around your question in terms of how we are
5 defining teaching proficiency and how we're
6 defining performance.
7 Q Well, let me ask you from your
8 perspective what is -- what is teaching
9 proficiency on the part of a CRNA?
10 MR. LAND: Just object as vague.
11 BY MS. SIEGEL:
12 Q You may answer.
13 A I'm sorry, I didn't hear you.
14 Q You may answer. By the way, my voice
15 can get soft. Don't hesitate to ask me to speak
16 up.
17 A Mine too. I sort of talk into my
18 chest sometimes.
19 Q Do you need the question back?
20 A No, ma'am. Thanks. Teaching
21 proficiency as I understand it, I mean, it goes
22 back to a person's nursing career because nurses
23 spend a lot of time educating patients and their
24 families.

Page 40

1 So I think most nursing schools have
2 content that teaches sort of basic concepts of
3 instruction, communication and then, you know,
4 things like peer education, being a clinical
5 preceptor, you know, of one's unit that those all
6 involve teaching.
7 And in the CRNA role patient education
8 is especially important because most surgical
9 patients today are same-day admissions or
10 out-patients and we are meeting them at the last
11 minute. So trying to establish a rapport with
12 the patient and their family, discuss the
13 anesthetic options along with the risks and
14 benefits involves a lot of teaching that has to
15 be geared toward the patient, you know, their
16 cultural and other aspects of their background
17 that impact their comprehension.
18 So I think that there is a skill set
19 that nurses and nurse anesthetists have that
20 pertains to teaching. The unique thing about
21 nurse anesthesia education is that the CRNA's
22 primary responsibility is to the patient and
23 maintaining patient safety.
24 Q And is teaching proficiency a

Page 41

1 significant factor of CRNA performance with
2 respect to the SRNAs?
3 A Can you repeat the question?
4 (Record read by the reporter as
5 follows:
6 "Q And is teaching
7 proficiency a significant
8 factor of CRNA performance
9 with respect to the SRNAs?")
10 THE WITNESS: I'm not following.
11 BY MS. SIEGEL:
12 Q Okay. Does it matter how CRNAs teach
13 SRNAs?
14 A I'm not trying to be difficult, but
15 does it matter to whom?
16 Q To you as a program director?
17 A Yes, it matters to me as a program
18 director how CRNAs or anesthesiologists teach
19 SRNAs.
20 Q And how do you evaluate that teaching
21 proficiency?
22 A Through clinical instructors'
23 evaluations, through student performance. If a
24 student, for example, is struggling in a

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 42

Page 43

1 particular clinical setting, we will bring them
2 back to the main medical center to Rush and pair
3 them one to one with CRNAs who are experienced
4 clinical instructors.

5 The -- you know, and I've removed
6 students from clinical sites when I've had
7 concerns about the educational environment
8 including instruction by the anesthesia
9 providers.

10 MR. LAND: Can we take a quick break?

11 MS. SIEGEL: Sure.

12 (Whereupon a recess was taken
13 at 10:12 a.m. and the
14 deposition resumed at 10:32
15 a.m.)

16 BY MS. SIEGEL:

17 Q Dr. Kremer, before the break you were
18 referring to an incident that you witnessed
19 between Miss Wimberly and an SRNA in the
20 endoscopy area; do you recall that?

21 A Yes, ma'am.

22 Q And was that student a person named
23 Hakim Ellis?

24 A No, it was not. It was Sarah Curry.

1 Q And did you have occasion to witness
2 an interaction between Mr. Ellis and Jill
3 Wimberly?

4 A Not that I recall.

5 Q Was there a dispute between Mr. Ellis
6 and Miss Wimberly regarding whether he had made a
7 telephone call to her?

8 A I have no idea.

9 Q You witnessed no such dispute?

10 A I did not.

11 Q And did Mr. Ellis express to you at
12 any time any objections regarding Miss Wimberly?

13 A Not that I recall.

14 Q Now, of course, you know that Miss
15 Wimberly is a defendant in this matter, right?

16 A Yes, ma'am.

17 Q Have you ever had a CRNA as a
18 defendant in a litigation matter during the time
19 you were director of the CRNA program?

20 MR. LAND: Just object as vague. You're
21 asking if he knows of any CRNA while he's
22 director has been a party to any lawsuit as a
23 defendant?

24 MS. SIEGEL: That's right.

Page 44

Page 45

1 THE WITNESS: Which CRNAs are we talking
2 about?

3 BY MS. SIEGEL:

4 Q Any CRNAs at Rush?

5 A I wouldn't -- I wouldn't know that.

6 Q It never came to your attention?

7 A No, it wouldn't come to my attention.

8 Q Okay. And Miss Wimberly is the only
9 case that you're aware of regarding the CRNAs
10 that you supervised as program director?

11 A I was not Miss Wimberly's supervisor.
12 Mr. Narbone was.

13 Q What were his duties?

14 A Mr. Narbone?

15 Q Yes, as supervisor of the CRNAs?

16 A He was the Chief Nurse Anesthetist and
17 Director of Anesthesiology Operations. He had a
18 wide scope of authority.

19 Q Whom did he report to?

20 A The chair of the anesthesia
21 department.

22 Q Who is that?

23 A Dr. Kenneth Tuman.

24 Q Whom did you report to during the time

1 that you were program director?

2 A The chair of my department, the Adult
3 Health and Gerontological Nursing Department as
4 well as the Assistant Dean for Specialty
5 Programs.

6 (Discussion outside the
7 record.)

8 BY MS. SIEGEL:

9 Q Dr. Kremer, I am handing you what's
10 previously been marked as Plaintiff's Exhibit 3,
11 and I'm asking you if you recognize this
12 document?

13 A I do.

14 Q And this is the defendants' answer to
15 plaintiff's first set of interrogatories; is that
16 right?

17 A That's right.

18 Q And is that a document that you
19 reviewed in anticipation of this litigation?

20 A I did.

21 Q Okay. And in anticipation of this
22 deposition?

23 A I thought I answered that.

24 Q I said litigation.

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 46

1 A I have reviewed the document.
 2 Q When did you review it?
 3 A Counsel provided it to me some time
 4 ago for review and signature.
 5 Q And if you turn to page 13, is that
 6 your signature?
 7 A It is.
 8 Q Okay. Now, after -- Strike that.
 9 Miss Marcial took a leave of absence
 10 from the CRNA program; isn't that right?
 11 A That's right.
 12 Q And when was that initiated?
 13 A I believe it was --
 14 Q When did it begin, just ask that?
 15 A I believe it was for the fall 2013
 16 academic term.
 17 Q And when did she return?
 18 A In January of 2014.
 19 Q And in January of 2014 Miss Marcial
 20 was again assigned to Miss Wimberly; is that
 21 right?
 22 A She was assigned with Miss Wimberly
 23 once in January of 2014.
 24 Q Do you recall the date?

Page 47

1 A I do not.
 2 Q And when did it come to your attention
 3 that Miss Marcial would be working with Miss
 4 Wimberly in January of 2014?
 5 A It was probably after the fact that
 6 Maricel was assigned with Jill.
 7 Q But before she began the work?
 8 A Before she began what work?
 9 Q Strike that. The assignment itself
 10 occurred on a Friday; do you recall that?
 11 MR. LAND: Objection, misstating facts not
 12 in evidence.
 13 THE WITNESS: As I mentioned earlier, we
 14 have up to 72 students in clinical practicum or
 15 residency at 10 different clinical sites at any
 16 given time. And I don't see the clinical
 17 assignments for each site every day.
 18 BY MS. SIEGEL:
 19 Q Did you -- Were you notified several
 20 days before -- let's get out the evaluation for
 21 that date.
 22 (Discussion outside the
 23 record.)
 24

Page 48

1 (Whereupon said document was
 2 marked as Plaintiff's Exhibit
 3 Number 11, for
 4 identification, dated
 5 3/16/18.)
 6 BY MS. SIEGEL:
 7 Q Okay. I've handed you a rather
 8 voluminous document here that we have marked as
 9 Plaintiff's Exhibit 11. And if you would take a
 10 look at that for a moment and tell me if you
 11 recognize that document?
 12 A Does Exhibit 11 refer to all of this
 13 in aggregate?
 14 Q Yes. For the record Plaintiff's
 15 Exhibit 11 is compilation of evaluations. It is
 16 Bates numbered Rush 1 through Rush 452.
 17 And if you take a look at that, I'm
 18 not asking you whether that's all of Miss
 19 Marcial's evaluations; but tell me if you
 20 recognize what this compilation is? This is how
 21 we received it from the --
 22 MR. LAND: I just want to note that this
 23 exhibit contains pages marked Rush 1 through 40
 24 and then there is a gap. The next page is Rush

Page 49

1 391. So there are many pages missing in the
 2 sequence in which it was produced. And it
 3 includes documents like the learning contract at
 4 page 392 and, I don't know, other materials from
 5 2014. Evaluations near the end. And the first
 6 page is Marcial summative evaluation from 2013.
 7 So my point is that this exhibit is a
 8 compilation of many documents and it does not
 9 contain the sequential numbering as it was
 10 produced. So I don't know what you want the
 11 witness to do with respect to clarifying what
 12 this is or not, but I want that to be clear on
 13 the record.
 14 MS. SIEGEL: All right. Thank you.
 15 BY MS. SIEGEL:
 16 Q Why don't we come back to that one.
 17 If you would turn, please, to page Rush 96 in
 18 that compilation. You are familiar with that
 19 document?
 20 A I have seen it, yes.
 21 Q Can you tell me what that is, please?
 22 A It's an informative clinical
 23 evaluation.
 24 Q All right. And it's dated January

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 50

Page 51

1 20th of 2014; is that right?
 2 A That's right.
 3 Q And when did you first see this
 4 evaluation?
 5 A I don't recall.
 6 Q This is a 2-page document; is that
 7 right, numbered pages 96 and 97?
 8 A Yes.
 9 Q Rush numbers 96 and 97. And that
 10 evaluation was performed by Miss Wimberly; is
 11 that right?
 12 A Yes.
 13 Q The morning of this procedure -- and
 14 can you tell me what the procedure was, please?
 15 A I don't know that the procedure was
 16 performed in the morning.
 17 Q All right. The day of January 20th of
 18 2014; can you tell me what that procedure was,
 19 please?
 20 A I think there are -- well, there are
 21 two procedures listed. So I don't know if they
 22 did do two cases together or if this represents
 23 one case.
 24 The cases listed are anterior -- looks

1 like spine fusion abdominal approach. And below
 2 that is right ankle arthrodesis. So those could
 3 be two different cases or it could be the same
 4 patient having two different orthopaedic
 5 procedures.
 6 Q And that's not something you can tell
 7 from this document from looking at it?
 8 A No, I cannot.
 9 Q Take a moment and look at the comments
 10 and see if you can sort out which comments
 11 pertain to which procedure?
 12 A Well, the Bates number Rush 97 is cut
 13 off at the top. So I don't have a full set of
 14 comments to review.
 15 Q Based on the comments that you have
 16 before you, can you sort out which comments
 17 pertain to which procedure?
 18 A No.
 19 Q Did you learn that Miss Marcial, and I
 20 believe I've asked you before, but perhaps this
 21 document refreshes your recollection. That Miss
 22 Marcial would be working with Miss Wimberly on
 23 January 20th of 2014 prior to the procedure or
 24 procedures that are reflected here?

Page 52

Page 53

1 A No.
 2 Q In the course of your work during that
 3 time period, you would from time to time go
 4 around the hospital; isn't that right?
 5 A I don't understand the question.
 6 Q Was it your practice from time to time
 7 to circulate around the operating area to observe
 8 the work of the CRNAs and the SRNAs?
 9 A I made rounds on a regular basis and
 10 the perioperative areas.
 11 Q I'm sorry, in the perioperative?
 12 A Perioperative areas.
 13 Q Okay. Can you explain for the record
 14 what the perioperative areas are, please?
 15 A Sure. The preoperative holding area,
 16 operating rooms and procedure rooms and
 17 postanesthesia recovery areas.
 18 Q And why did you make rounds?
 19 A I made rounds to be visible as the
 20 program director, to talk to staff about any
 21 issues that might be impacting students, to
 22 occasionally observe cases and to pick up student
 23 evaluations which are deposited in a locked box
 24 in the -- in an area on the five tower operating

1 room.
 2 Q And when you make rounds do you
 3 typically have someone with you?
 4 A When I make rounds it's really just me
 5 making rounds.
 6 Q And so as I understand it, you don't
 7 have any recollection of seeing Miss Marcial and
 8 Miss Wimberly working together on the day of
 9 January 20th of 2014?
 10 A I do not.
 11 Q Is this a kind of case where a --
 12 where the CRNA or the SRNA would ordinarily order
 13 blood to be available in the operating room?
 14 A If it was indicated, yes.
 15 Q What would cause it to be indicated?
 16 A The potential for significant blood
 17 loss that is engendered by a transabdominal
 18 approach to the spine where surgeons are going to
 19 be working in close proximity to great vessels.
 20 Q And do you have an opinion regarding
 21 the risk of the type of procedure that's
 22 indicated here, the anterior --
 23 MR. LAND: Just object as vague.
 24 THE WITNESS: I'm not following. Risk in

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 54

1 what regard?
 2 MS. SIEGEL: Could you have a -- Could you
 3 read the question back, please.
 4 (Record read by the reporter as
 5 follows:
 6 "Q And do you have an opinion
 7 regarding the risk of the type
 8 of procedure that's indicated
 9 here, the anterior --")
 10 BY MS. SIEGEL:
 11 Q Do you have an opinion regarding the
 12 risk of excessive bleeding in the type of
 13 procedure, the anterior abdominal approach, to
 14 the spine?
 15 A There is a significant risk of major
 16 blood loss with a procedure like this.
 17 Q And what is the basis of that opinion?
 18 A As stated earlier, the proximity of
 19 the aorta, the vena cava, iliac arteries, to the
 20 surgical field and the potential for surgeons to
 21 inadvertently nick or even transect one of those
 22 vessels. And even absent major vascular trauma,
 23 the nature of the wound itself and
 24 instrumentation of the spine can also produce

Page 55

1 significant bleeding.
 2 Q And would you anticipate that the
 3 surgeons would also have an awareness of the risk
 4 of excessive bleeding based on the factors that
 5 you've indicated?
 6 A The surgeons would have an awareness
 7 of the potential for bleeding, but surgeons
 8 notoriously underestimate how much blood they may
 9 lose, they have lost, as well as how long their
 10 procedures take.
 11 Q And you state that surgeons are
 12 notorious for this underestimation of these risk
 13 factors?
 14 A I think it's fairly common based on 35
 15 years of clinical practice, yes.
 16 Q Are you -- When you say it's
 17 notorious, is that your opinion that you're
 18 talking about?
 19 A I am expressing it as my opinion, yes.
 20 Q And when you're saying that it's
 21 notorious, you're not referring to a general
 22 reputation that surgeons have for being unable to
 23 anticipate how much blood might be needed?
 24 MR. LAND: Can you read that question back.

Page 56

1 (Record read by the reporter as
 2 follows:
 3 "Q And when you're saying
 4 that it's notorious, you're
 5 not referring to a general
 6 reputation that surgeons have
 7 for being unable to anticipate
 8 how much blood might be
 9 needed?")
 10 MR. LAND: Object, it's mischaracterizing
 11 his testimony and the form of the question is
 12 vague.
 13 MS. SIEGEL: Let me rephrase it.
 14 BY MS. SIEGEL:
 15 Q Dr. Kremer, when you say that surgeons
 16 are notorious for underestimating how much blood
 17 might be needed, how much bleeding might be
 18 occurred and how much blood might be needed; are
 19 you stating that that's a general reputation that
 20 surgeons have?
 21 A To be more precise some surgeons are
 22 more likely than others to underestimate how much
 23 blood they may lose or they have lost which is
 24 why it's incumbent on anesthesia providers to be

Page 57

1 prepared for any contingency.
 2 Q And, Dr. Kremer, would that
 3 preparation involve blood typing for example?
 4 A Yes.
 5 Q And is there some kind of procedure
 6 that one would expect to be performed in order to
 7 prepare for this anterior abdominal approach
 8 spinal procedure?
 9 A Probably a minimum of type and screen
 10 and there are people who would probably even want
 11 to have a couple of units of blood typed and
 12 crossmatched.
 13 Q And where would that blood be, in the
 14 blood bank?
 15 A I'm not following.
 16 Q Okay. Where would those units, the
 17 units that were typed and crossmatched,
 18 physically where would they be?
 19 A Well, there is a central blood bank
 20 and then there are satellite blood banks in the
 21 operating room.
 22 Q And for this type of procedure where
 23 would you anticipate that they would be?
 24 A If blood is typed and crossmatched, it

1 should be in the satellite blood bank.
 2 Q And when would such arrangements be
 3 made?
 4 A It may be indicated on the surgical
 5 schedule. Surgeons may have placed orders for
 6 type and screen or type and cross. Failing
 7 either of those there would be a discussion
 8 perhaps between the anesthesia team and the
 9 surgical team, but the anesthesia team would have
 10 the prerogative of having blood available if they
 11 felt it was indicated.
 12 Q Did you have a discussion with Miss
 13 Marcial about the January 20th, 2014, evaluation?
 14 A Probably at some point after the
 15 evaluation was submitted.
 16 Q Do you have a recollection of it?
 17 A I do not.
 18 Q Did you have a discussion with Miss
 19 Wimberly about it?
 20 A I don't recall.
 21 MS. SIEGEL: Now, mark this as the next
 22 exhibit, please.
 23
 24

1 (Whereupon said document was
 2 marked as Plaintiff's Exhibit
 3 Number 12, for identification,
 4 dated 3/16/18.)
 5 BY MS. SIEGEL:
 6 Q Dr. Kremer, we have marked a document
 7 here. Actually, it's already in evidence, but
 8 I've marked it for your convenience as
 9 Plaintiff's Exhibit 12.
 10 And you've mentioned that you spoke
 11 with Mr. Narbone from time to time concerning
 12 Miss Wimberly's contact with Miss Marcial. Is
 13 that the only time -- Strike that.
 14 Did you not also have a conversation
 15 with Miss Marcial and Mr. Narbone regarding her
 16 continuation in the program in October of 2013?
 17 A Yes.
 18 MR. LAND: Just object to the form of the
 19 question. You struck something and then said did
 20 you also have such a conversation, so I object to
 21 the form.
 22 BY MS. SIEGEL:
 23 Q You may answer.
 24 A I answered.

1 Q Okay. And your answer is, yes, you
 2 did have such a discussion?
 3 A Yes, ma'am.
 4 Q So first Miss Marcial came to speak
 5 with you at your office; is that right?
 6 A I believe that's right.
 7 Q And that was approximately October
 8 24th of 2013?
 9 A I don't have that in evidence in front
 10 of me. I couldn't say.
 11 Q All right. But you do recall that in
 12 October of 2013 you had a conversation with Miss
 13 Marcial about her return?
 14 A Yes.
 15 Q From her leave of absence, right?
 16 A Yes.
 17 Q And she came was it to your office?
 18 A She may have. I don't have an
 19 explicit memory.
 20 Q Before you met with Mr. Narbone, was
 21 anyone else present in your office when you began
 22 speaking with Miss Marcial?
 23 MR. LAND: Just object to the form of the
 24 question. He just said he doesn't recall whether

1 he was in his office talking with Maricel.
 2 Object to the form.
 3 BY MS. SIEGEL:
 4 Q All right. You may answer.
 5 A I think it's unlikely that there was
 6 anyone else involved in the conversation that
 7 you've mentioned except Mr. Narbone and me
 8 because Dr. Wiley was on an Army deployment
 9 overseas at the time.
 10 Q And as well as you can recall, what
 11 transpired during that meeting that you had with
 12 Miss Marcial in October of 2013 about her
 13 returning from her leave of absence?
 14 A I think when she and I talked we
 15 touched on what she had been doing during her
 16 leave in terms of stress management as well as
 17 observing some OR cases at Lutheran General and I
 18 think somewhere in Wisconsin.
 19 And then I wanted to involve Mr.
 20 Narbone in the conversation since he controlled
 21 all the clinical assignments to just kind of
 22 review that Maricel would be coming back in
 23 January and just hoping that we would all, you
 24 know, get on the same page in terms of what the

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 62

1 expectations would be.
 2 Q And before we get on to that meeting,
 3 what were your expectations of Miss Marcial's
 4 work when she returned from her LOA?
 5 A They were codified in the learning
 6 contract that Miss Marcial and I signed.
 7 Q Did you have other expectations going
 8 beyond that contract?
 9 A I think the contract is very detailed.
 10 Q And Miss Marcial had wanted to include
 11 some provisions to insure a lack of
 12 discrimination; isn't that right?
 13 A Yes. As I understand that
 14 conversation was recorded, and my best
 15 recollection of the conversation was that there
 16 was a request made for a guarantee of fair
 17 treatment and that was in a meeting with Dr. Mary
 18 Johnson, the Assistant Dean and myself.
 19 And Dr. Johnson said that's not
 20 something that can be measured and noted that
 21 students who were in jeopardy often perceive
 22 themselves as not being treated fairly. So that
 23 language wasn't added to the contract.
 24 Q Well, would you agree with Dr. Johnson

Page 63

1 that bias is in the eye of the beholder?
 2 MR. LAND: Just object as
 3 mischaracterizing --
 4 THE WITNESS: Doesn't characterize --
 5 MR. LAND: -- his testimony.
 6 THE WITNESS: -- that conversation at all.
 7 BY MS. SIEGEL:
 8 Q All right. So you -- After you spoke
 9 with Miss Marcial in your office, then you went
 10 to Mr. Narbone's office; is that right?
 11 A Are we referencing October of 2013?
 12 Q I'm talking about October of 2013,
 13 that's right.
 14 A Yes, we did.
 15 Q And Mr. Narbone was expecting you?
 16 A Yes, he was.
 17 Q And he was waiting for you. And what
 18 occurred?
 19 A We had a conversation about Maricel's
 20 return to the operating room in January, the plan
 21 to return to the operating room in January of
 22 2014.
 23 Q Didn't Mr. Narbone ask Miss Marcial
 24 why she wanted to be a nurse anesthetist?

Page 64

1 A He may have. I don't have an explicit
 2 recall of that conversation as your client does.
 3 Q And do you have a recollection that
 4 she indicated that she had a passion for critical
 5 care nursing?
 6 A I don't recall.
 7 Q Do you recall Mr. Narbone talking
 8 about whether or not that aspiration of Miss
 9 Marcial was a fit with the Rush program?
 10 A He may have said something to that
 11 effect.
 12 Q Do you recall him saying that she was
 13 like a square peg in a round hole?
 14 A I don't recall that specific
 15 statement.
 16 Q Do you recall him saying that she is
 17 pushing the envelope?
 18 A I don't recall that specific
 19 statement.
 20 Q How about that she couldn't force it,
 21 that it had to be a natural fit?
 22 A I don't recall that specific
 23 statement.
 24 Q Do you recall any general statements

Page 65

1 along those lines that Miss Marcial didn't fit
 2 in?
 3 MR. LAND: Object as mischaracterizing the
 4 prior statements. You can answer.
 5 THE WITNESS: I wouldn't characterize the
 6 statements as indicating that Miss Marcial
 7 wouldn't fit.
 8 BY MS. SIEGEL:
 9 Q Did Mr. Narbone say that he expected
 10 that she was going to be coming back to inform
 11 the two of you that she would be dropping out in
 12 the program?
 13 A Can you repeat the question?
 14 Q Sure. Do you recall Mr. Narbone
 15 saying words to the effect that he assumed that
 16 Miss Marcial was going to be dropping out of the
 17 program?
 18 A I don't recall that, no.
 19 Q Or that he was surprised that she was
 20 still around?
 21 A I don't recall that.
 22 Q Do you recall him saying that another
 23 CRNA had heard that she was planning to return
 24 and said that -- expressed disappointment?

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 66

1 A I don't recall that.
 2 Q Do you think that if Mr. Narbone had
 3 said that, something to the effect that the CRNA
 4 program wasn't a fit for her; do you think that
 5 she would have -- do you think you would have
 6 recalled it?
 7 MR. LAND: Object as calling for
 8 speculation.
 9 BY MS. SIEGEL:
 10 Q You may answer.
 11 A I don't recall.
 12 Q Do you have any recollection of a
 13 warning -- a warning to Miss Marcial that if she
 14 tried to apply to another program, that --
 15 another anesthesia program, that they would --
 16 that you would have to talk about her poor
 17 performance at Rush?
 18 A I don't understand who that statement
 19 is attributed to.
 20 Q Well, was that statement made in that
 21 October meeting?
 22 A Not by me.
 23 Q Do you recall Mr. Narbone making a
 24 statement to that effect?

Page 67

1 A No, I don't.
 2 Q Do you recall him speaking with her
 3 about how she would react if she were in a
 4 situation in the OR where a child had a cardiac
 5 arrest?
 6 A I do not.
 7 Q Do you recall any discussion with her
 8 about the stressful nature of anesthesia
 9 practice?
 10 A A discussion initiated by whom?
 11 Q Any discussion in the course of that
 12 October -- that October 2013 meeting with you and
 13 Mr. Narbone and Miss Marcial?
 14 A It may have been discussed.
 15 Q Do you recall anything about it?
 16 A I do not.
 17 Q Do you recall any discussion about
 18 whether Miss Marcial were emotionally fit to
 19 serve as a CRNA?
 20 A I don't recall statements like that
 21 being made.
 22 Q No, I was asking generally about
 23 whether there were a discussion of her emotional
 24 fitness to continue in the program?

Page 68

1 MR. LAND: Just object to the form of the
 2 question as argumentative. Starting with no and
 3 telling him that's not what you want him to say
 4 is the implication because he answered your
 5 question. That's why I am --
 6 MS. SIEGEL: Mr. Land, I said no in terms of
 7 the question to clarify what the question was.
 8 MR. LAND: I am just stating it for the
 9 record. You are challenging his answer instead
 10 of asking him another question.
 11 MS. SIEGEL: Let's have the question back.
 12 That's not correct.
 13 (Record read by the reporter as
 14 follows:
 15 "Q No, I was asking generally
 16 about whether there were a
 17 discussion of her emotional
 18 fitness to continue in the
 19 program?")
 20 BY MS. SIEGEL:
 21 Q Do you understand the question?
 22 A What is the question?
 23 Q Was there a discussion at the October
 24 2013 meeting with Mr. Narbone and Ms. Marcial and

Page 69

1 yourself regarding her emotional fitness to
 2 continue in the program?
 3 A I don't recall.
 4 Q Do you recall any discussion about her
 5 emotional fitness to enter the profession of the
 6 CRNA?
 7 A I don't recall.
 8 Q Do you recall any discussion about
 9 whether she could handle herself in stressful
 10 situations having come out of an ICU background
 11 for many years?
 12 A I don't remember a question being
 13 asked that was constructed in that manner.
 14 Q Do you recall making a statement to
 15 the effect that Miss Marcial had been a nurse for
 16 so long that this was a whole different challenge
 17 to go into the CRNA field?
 18 A During the October 2013 meeting?
 19 Q During the October 2013 meeting,
 20 that's right.
 21 A I may have made a statement to that
 22 effect.
 23 Q As you sit here today do you think
 24 that's true?

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 70

1 A Do I think what's true?
 2 MS. SIEGEL: Can we have the question --
 3 prior question back, please.
 4 (Record read by the reporter as
 5 follows:
 6 "Q Do you recall making a
 7 statement to the effect that
 8 Miss Marcial had been a nurse
 9 for so long that this was a
 10 whole different challenge to
 11 go into the CRNA field?")
 12 BY MS. SIEGEL:
 13 Q As you sit here today do you think
 14 that's true?
 15 A It's challenging for any nurse to
 16 become a CRNA.
 17 Q Did you think that it was a particular
 18 challenge for Miss Marcial because she had been a
 19 nurse for many years before applying to your
 20 program?
 21 A I may have said something to that
 22 effect, but I don't explicitly recall that
 23 conversation.
 24 Q Did Mr. Narbone to your recollection

Page 72

1 A He may have said something to that
 2 effect.
 3 Q Do you have a more specific
 4 recollection as to what he may have said about an
 5 uphill battle?
 6 A No, I didn't create a transcript of
 7 his conversation so I don't have explicit recall
 8 of it.
 9 Q Did someone make a transcript of it?
 10 A Your client seems to have very
 11 explicit recall of what was discussed.
 12 Q Have you reviewed what her
 13 recollection was?
 14 A I didn't hear the question.
 15 Q Have you reviewed what her
 16 recollection was?
 17 A I don't think I had access to that
 18 documentation.
 19 Q Did Mr. Narbone make a statement to
 20 the effect that if she made a mistake, that the
 21 CRNAs would look at it with more skepticism than
 22 when she first began her work?
 23 A I don't recall.
 24 Q Do you recall a discussion about the

Page 71

1 make a statement to the effect that were Miss
 2 Marcial to return, she could expect the CRNAs to
 3 be rougher on her than they had been in the past?
 4 A I don't remember a statement to that
 5 effect being made.
 6 Q Do you remember them -- Strike that.
 7 Do you remember Mr. Narbone making a
 8 statement to the effect that when she came back
 9 that the CRNAs would look at her differently?
 10 A He may have said something to that
 11 effect.
 12 Q Do you recall him saying something to
 13 the effect that if he asked the CRNA's at Rush
 14 about her return, that they would vote not to
 15 have her return?
 16 A I don't remember him saying anything
 17 like that.
 18 Q Did you make a statement that you had
 19 met with the CRNAs that week and many of them
 20 showed some skepticism about whether Miss Marcial
 21 should return?
 22 A I don't recall.
 23 Q Did he say that it would be more than
 24 an uphill battle for her?

Page 73

1 gap between the SRNAs and her cohort how far
 2 ahead of her they would be upon her return?
 3 A Does this question also pertain to the
 4 meeting that Maricel and I had with Mr. Narbone
 5 in October of '13?
 6 Q Yes.
 7 A I don't remember that.
 8 Q Do you remember a discussion like that
 9 at any time?
 10 A No, I don't.
 11 Q Did he say anything about the kind of
 12 example that she would be setting? And by he I
 13 mean Mr. Narbone.
 14 Did he say anything about the kind of
 15 example he would be setting if he allowed her to
 16 come back?
 17 A It wasn't his decision to allow her to
 18 come back, so I don't know what the context for
 19 that question would have been.
 20 Q Whose decision would it be, your's?
 21 A The nurse anesthesia program.
 22 Q Okay. Who would effectively make that
 23 decision?
 24 A Well, following a grade of withdraw

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 74

1 nonpassed, the College of Nursing Progressions
2 Committee would grant permission to repeat the
3 course and the program would implement that.
4 Q Did Mr. Narbone express in that
5 October 2013 meeting a view that her return would
6 lower the high standards of the Rush program?
7 A Not that I remember, no.
8 Q Did Mr. Narbone in that October 2013
9 meeting say something to the effect that if she
10 -- Strike that.
11 Did he make a statement to the effect
12 that if she waited to flunk out, that you're just
13 looking at the inevitable?
14 A I don't know what that means and I
15 don't recall a statement to that effect.
16 Q Okay. Did he say, I'm going to tell
17 you I told you so if she flunked out?
18 A He may have said something to that
19 effect.
20 Q What's your best recollection of what
21 he said?
22 A My best recollection is that Mr.
23 Narbone may have made a statement of -- to that
24 effect.

Page 75

1 Q Did he say that he didn't suppose that
2 Miss Marcial was the youngest in her class?
3 A I don't recall.
4 Q Did he ask her why she would waste her
5 time doing something that would make her
6 miserable?
7 A I don't remember a statement like
8 that.
9 Q Did he suggest that she find out where
10 she could be truly successful and try to be
11 happy?
12 A He may have said something to that
13 effect.
14 Q Do you recall that he made a statement
15 to that effect?
16 A He may have made a statement to that
17 effect.
18 Q Did Mr. Narbone say that when Miss
19 Marcial -- Strike that.
20 Did he make a statement to the effect
21 that if Miss Marcial graduated, that he would
22 like to get an invitation?
23 A I have no recall of a statement to
24 that effect.

Page 76

1 Q Was Miss Marcial upset by that
2 meeting?
3 A Yes, she was.
4 Q How could you tell?
5 A If I remember she was tearful.
6 Q Did you say anything during that
7 meeting?
8 A Yes.
9 Q What did you say?
10 A I don't recall.
11 Q Did you say anything to Miss Marcial
12 that day after you left the meeting?
13 A I think I apologized for the tone of
14 the meeting and wanted to encourage her to think
15 positively about the future and about coming
16 back.
17 Q Why did you apologize about the tone
18 of the meeting?
19 A Because Miss Marcial was upset.
20 Q Did you see anything going on that
21 would make her upset?
22 A No, I didn't see anything going on
23 that would have made her upset.
24 Q Did you hear anything that would make

Page 77

1 her upset?
2 A Mr. Narbone can be kind of blunt at
3 times and he may have said things that were
4 upsetting to Miss Marcial.
5 Q Did you agree with what he was saying?
6 A No.
7 Q What didn't you agree with?
8 A I don't have a transcript of that
9 meeting in front of me.
10 Q Based on your recollection is there
11 anything that was said at the meeting that you
12 don't agree with?
13 A I don't recall.
14 Q Did you make any notes of that
15 meeting?
16 A I don't recall.
17 Q Had you made notes where would you
18 have kept them?
19 A I didn't hear the question.
20 Q Where would you have kept the notes
21 had you made any?
22 A In the student's file.
23 Q Did you have a file for Miss Marcial?
24 A All students have a file.

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 78

1 Q Did you have a file that you
2 maintained for Miss Marcial?
3 A Miss Marcial and all the other nurse
4 anesthesia students have files that are kept in
5 locked cabinets.
6 Q Where are they?
7 A The exact location is room 1060F at
8 the Armour Academic Facility of Rush University
9 Medical Center that's located at 600 South
10 Paulina Street in Chicago.
11 Q Thank you. And where is it with
12 reference to your office?
13 A Down the hall and around the corner.
14 Q Are you the person that maintains that
15 file?
16 A I am not.
17 Q Who does?
18 A Our program assistant.
19 Q And had you made a note on that
20 meeting, would it have become part of Miss
21 Marcial's permanent record?
22 A It may have.
23 Q Did you have any other files where you
24 kept notes on student issues?

Page 79

1 A The student files, they're a
2 repository for any notes about student issues.
3 Q After that October meeting did you
4 tell Miss Marcial that it would be more than an
5 uphill battle were she to return?
6 A I don't recall.
7 Q Did you say anything to the effect of
8 we just want you to be happy?
9 A I may have said something to that
10 effect.
11 Q Did you tell her to just try to find
12 her happiness?
13 A I may have said something to that
14 effect.
15 Q And did you think that she would find
16 happiness practicing as a CRNA?
17 A I couldn't say.
18 Q Did you have an opinion at the time as
19 to whether that would be a source of happiness
20 for her were she to return?
21 A I knew Miss Marcial very much wanted
22 to become a CRNA.
23 Q Did you think she was a good fit?
24 MR. LAND: Object as vague.

Page 80

1 BY MS. SIEGEL:
2 Q You may answer.
3 MR. LAND: Did she fit in the chair? Did
4 she fit in the room? That's a very vague
5 question.
6 BY MS. SIEGEL:
7 Q You may answer.
8 A She met the admissions criteria for
9 the program, and her academic performance and
10 initial clinical performance was satisfactory.
11 MS. SIEGEL: Why don't we take a short break
12 here.
13 (Whereupon a recess was taken
14 at 11:29 a.m. and the
15 deposition resumed at 11:43
16 a.m.)
17 (Whereupon said document was
18 marked as Plaintiff's Exhibit
19 Number 13, for identification,
20 dated 3/16/18.)
21 BY MS. SIEGEL:
22 Q Dr. Kremer, you've been handed what's
23 been marked as Plaintiff's Exhibit 13, and take a
24 moment to familiarize yourself with that. Tell

Page 81

1 me if you recognize that document?
2 A This appears to be the response I
3 submitted to the complaint that you and your
4 client submitted to the Council on Accreditation,
5 Nurse Anesthesia Educational Programs.
6 Q And did you draft any portions of
7 Plaintiff's Exhibit 13?
8 A I drafted all of it with input from
9 our Office of Legal Affairs and reviewed by my
10 direct reports in the college of nursing.
11 MR. LAND: Just advise you not to talk about
12 communication with counsel.
13 BY MS. SIEGEL:
14 Q Yes. And none of my questions are
15 intended to elicit privileged communications that
16 you had with your legal counsel whether outside
17 counsel or inhouse counsel. And so please do not
18 divulge those conversations.
19 And who were the direct reports you
20 consulted to prepare the documents?
21 A I sent drafts of the document that I
22 prepared to Dr. Rose Suhaypa, the Director of
23 Accreditation for our college now the entire
24 university. Dr. Mary Johnson, the Assistant Dean

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 82

1 I report to. And Dr. Mark Foreman, the Dean of
2 the College of Nursing.
3 Q And how did you go about preparing
4 this report, this response let's call it?
5 A I was given six weeks to prepare a
6 response to the complaint; and I wrote narratives
7 and found supporting exhibits, documentation and
8 data.
9 Q Who else was involved in the drafting
10 if anyone?
11 A I drafted the response.
12 Q What's the COA?
13 A The Council on Accreditation of Nurse
14 Anesthesia Educational Programs.
15 Q And what's its function?
16 A To insure quality improvement, quality
17 assessment of nurse anesthesia programs
18 consistent with their accreditation standards.
19 Q And in your role as program director,
20 was it your function to monitor compliance with
21 accreditation standards?
22 A Yes, it was.
23 Q Do you have a -- Strike that.
24 During the time period of 2012 through

Page 83

1 2015, did you have a position with the COA?
2 A I was an elected Director of the
3 Council on Accreditation between 2005 and 2012 or
4 2006 and 2012.
5 Q How did you get elected to the
6 directorship?
7 A In my case a sitting president of our
8 national organization submitted my name for
9 consideration and then the members of the council
10 vote.
11 Q Who were the members of the COA?
12 A Who were the members?
13 Q Who are the members generically, not
14 by name?
15 A Generically CRNA practitioner, CRNA
16 educator, hospital administrator, university
17 administrator, public member, student.
18 Q And do they also -- Strike that.
19 Are those members also chosen by an
20 election process?
21 A They are. I'm trying to remember if
22 -- I think the process may be a bit different for
23 how the student is selected, but the other
24 directors' names appear on the ballot and the

Page 84

1 current members of the council vote on the
2 ballot.
3 Q And is anyone else from Rush involved
4 directly with the COA?
5 A Not as a sitting council member.
6 Dr. Wiley and I have both been onsite reviewers
7 for the COA for over 20 years.
8 Q Do you still perform that function?
9 A I am still eligible to perform that
10 function, but I am not planning to continue doing
11 that. My eligibility runs out I think in
12 September.
13 Q Of 2018?
14 A Yes, ma'am. 2018.
15 Q What was the date that you submitted
16 Plaintiff's Exhibit 13 to the COA?
17 A I don't have that in evidence. It was
18 in advance of whatever the submission deadline
19 was.
20 Q Thank you. Now, once they've
21 completed the didactic component of the CRNA
22 program at Rush, how are the students graded?
23 A For clinical courses that would be a
24 pass, fail grade. And there in the master's

Page 85

1 curriculum there was a capstone during the final
2 term. There was a letter grade for the capstone.
3 Q Did Miss Marcial submit a capstone?
4 A She did.
5 Q What was the letter grade?
6 A I don't recall.
7 Q And how are the -- In the pass, fail
8 component of the clinical work, how are the CRNAs
9 evaluated?
10 A The CRNAs aren't evaluated.
11 Q I'm sorry, the SRNAs. I misspoke.
12 A They're evaluated using a formative
13 evaluation tool.
14 Q And then is there also a summative
15 evaluation that they reach, that they receive?
16 A Yes, there is a summative evaluation
17 that's generated at the end of each academic
18 term.
19 Q In the 2013 and 2014 time period, what
20 were the academic terms?
21 A The college of nursing was
22 transitioning from academic -- 10-week academic
23 quarters to 15-week basically semesters in that
24 timeframe. So for our last master's cohort we

1 had to completely reorganize the curriculum to
2 follow the new calendar and --
3 Q The semester calendar?
4 A Yes, and I believe the semester
5 calendar took effect in 2014.
6 Q When in 2014? I'm asking to get a
7 sense of how you move from the -- from quarters
8 to semesters?
9 A There was a transition year and it's
10 kind of a blur because we admitted our final
11 master's cohort in June of 2012 and our first DNP
12 cohort in September of 2012. And the change to
13 -- now I'm trying to remember when exactly the
14 change in academic terms occurred. We may have
15 -- we may have been on semesters by the 2013-2014
16 timeframe.
17 Q Thank you. Who does the summatives?
18 A Our core faculty members. So they're
19 done by four or five of the CRNA faculty.
20 Q And in the 2013-2014 period, who would
21 that include?
22 A Myself, Dr. Wiley, Dr. Przygodzka.
23 Q Can you spell that for the court
24 reporter?

1 A Yes, ma'am. P-r-z-y-g-o-d-z-k-a. Mr.
2 Keith Marino would have been another one who was
3 involved in writing summative evaluations.
4 Q Anyone else?
5 A We had two other part-time faculty
6 members who were with us around that time; Susan
7 McMullan, M-c-M-u-l-l-a-n, and Sherwin Samson,
8 S-a-m-s-o-n. I can't say for sure if they wrote
9 summative evaluations in that timeframe, but they
10 were also part-time academic faculty.
11 Q And are MDs and CRNAs both competent
12 to do evaluations of SRNAs?
13 A Yes.
14 Q In preparing a summative evaluation,
15 do you weigh one type of evaluation more than the
16 other as MDs versus CRNAs?
17 A No, we're grateful for any of them
18 that we get.
19 Q And how many are the students supposed
20 to submit?
21 A At least 2 per week. So now we have
22 14 weeks of instruction and 1 week for exams. So
23 minimum of 28 per term.
24 Q And is there any other means besides

1 evaluations by which you grade or judge student
2 performance, SRNA performance?
3 A Does the question relate to clinical
4 performance?
5 Q Yes.
6 A The evaluations are the main source of
7 data for evaluating student performance. And the
8 meetings with clinical instructors that we have
9 periodically also can help with that.
10 Q And in what role do the meetings with
11 clinical instructors play in evaluating student
12 work?
13 A Those meetings help verify and clarify
14 what is submitted in the formative evaluations or
15 they may be feedback that isn't reflected in
16 formative evaluations that comes up at those
17 meetings.
18 Q And so are the meetings with the
19 clinical instructors, are those -- are you
20 talking about individual meetings or organized
21 meetings of the instructors?
22 A They're organized like bimonthly
23 meetings.
24 Q And who attends them?

1 A Any of the clinical instructors who
2 are available and now the Chief CRNA attends them
3 as well.
4 Q You say now the Chief CRNA attends.
5 When did the Chief CRNA start attending those
6 meetings?
7 A Well, Mr. Narbone's successor, Jim
8 Miller, is the Chief CRNA, so he attends those
9 meetings as well.
10 Q And how did Jim Miller become the
11 Chief?
12 A I really don't know. That was a
13 process that was internal to the Department of
14 Anesthesia.
15 Q Were you involved in the choice?
16 A No.
17 Q And, now, students are expected to
18 have two evaluations a week. May they submit
19 more?
20 A They may submit more and we strongly
21 encourage them when they're starting out to try
22 to get an evaluation every day. We -- as you've
23 seen we have mostly paper-based evaluations.
24 Some are electronic, but the turnaround process

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 90

1 can be a little long sometimes from, you know,
2 when a student hands out an evaluation to when
3 it's returned. So and some don't get returned.
4 So it's really helpful to have a robust number of
5 evaluations so that faculty have the best
6 representation of how performance has been
7 trending.
8 Q Did you do anything to control the
9 accuracy of evaluations speaking generally?
10 A I don't understand the question.
11 Q Strike that. Let's talk for another
12 couple minutes about these departmental meetings,
13 these bimonthly departmental meetings.
14 So they were attended by the people
15 that were in the hospital on that date, is that
16 typically the way that the attendance worked?
17 A Yes, that's right.
18 Q And it wasn't a requirement?
19 A No.
20 Q Were there any specific number -- was
21 there any specific number of meetings that they
22 were expected to attend?
23 A No.
24 Q And what was discussed at those

Page 91

1 meetings?
2 A The focus of those meetings was -- and
3 I mentioned earlier it's a longstanding practice
4 in the program to have regular, we call it,
5 clinical competence review. So we have a minimum
6 of 48 students who are clinically deployed at
7 given times. Sometimes more. So we have maybe
8 45 minutes to meet. So it's difficult to cover
9 -- cover each of them in detail.
10 But the idea is to get a sense of how
11 things are trending for individual students and
12 at certain times of the year to determine when
13 faculty feel they're able to work without
14 one-on-one continuous supervision.
15 Q And can you -- can you give an example
16 of the kind of discussion that you would have
17 about a student in this competency review?
18 A We have composite pictures of the
19 cohort on the table and we basically go down the
20 list in alphabetical order and say has anybody
21 worked with Mike Kremer. If they have, they'll
22 speak up or they'll say, no, I haven't seen him
23 for a while. If it's something that looks like
24 it may take a little more time to discuss, then

Page 92

1 we take that offline.
2 But the idea is just to get overall
3 trends with individual student performance and
4 get a sense of who is doing really well, who is
5 at about where they are expected to be, you know,
6 for their level of training and who may need more
7 support.
8 Q And you say that you took it offline,
9 were the meetings online somehow?
10 A Oh, I was using a figure of speech
11 there just meaning that if an attendee had
12 specific concerns that they might want to discuss
13 in more detail, I would talk to them privately
14 after the meeting or at some other mutually
15 convenient time.
16 Q So you had -- you had composite
17 pictures of the cohort on the table. Do you mean
18 that you had evaluations that were spread on the
19 table?
20 A No, I mean a composite picture,
21 photographs of each cohort. Because we have so
22 many students, people can't always remember names
23 and faces.
24 Q I see. And, I'm sorry, I'm just

Page 93

1 trying to visualize this.
2 A Right. Right.
3 Q So the pictures are on the table. So
4 you would point to a picture say of, oh, Miss
5 Marcial and say, has anybody worked with her; is
6 that how it would go?
7 A The pictures are there for reference.
8 I'm going down a list in alphabetical order.
9 Q I see. And so if somebody didn't
10 recognize a name --
11 A I'm sorry.
12 Q I'm sorry, I'm just trying to get the
13 picture. The pictures had the names on them?
14 A Uh-huh.
15 Q Okay. I understand. About how much
16 time would be devoted to each student?
17 A Well, given the time constraints, I
18 mean, a minute. And there were times we had
19 program business to discuss too as far as, you
20 know, if we were adding a new clinical site or
21 something like that that I would try to sandwich
22 in at the end.
23 Q Okay. And then were recordings made
24 of those meetings?

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 94

1 A Not to my knowledge.
 2 Q Were minutes kept?
 3 A Yes, minutes were kept.
 4 Q Who kept them?
 5 A Either Dr. Wiley or me.
 6 Q And were the minutes circulated to the
 7 clinical faculty?
 8 A No, they were not.
 9 Q Were they circulated to anybody?
 10 A No.
 11 Q Were the CRNAs regarded as
 12 gatekeepers?
 13 A Regarded by whom as gatekeepers?
 14 Q Did the program regard the CRNAs as
 15 gatekeepers, the program administration?
 16 A No.
 17 Q Have you ever heard the term used?
 18 A I have.
 19 Q In connection with CRNA evaluations of
 20 students?
 21 A Not in that context, no.
 22 Q Have you heard it in the context of
 23 the functioning of the CRNA program at Rush?
 24 A I'm not following. I'm sorry.

Page 96

1 BY MS. SIEGEL:
 2 Q Is there anything that you do to
 3 insure the objectivity of the CRNA evaluations?
 4 A I can't insure that they're objective.
 5 I can monitor trends and evaluations that are
 6 produced by different evaluators. Some of our
 7 anesthesiologists will check on the tool. It has
 8 the Likert scale from zero to five. They will
 9 give everybody five's all the time. So that kind
 10 of feedback can be less helpful.
 11 Q Have you had any discussions with any
 12 of the anesthesiologists about the -- their use
 13 of the evaluation instrument with the Likert
 14 scale?
 15 A If I've had discussions of that
 16 nature, it would have been with the department
 17 chair.
 18 Q Do you recall in the 2013 and 2014
 19 academic years, do you recall having discussions
 20 like that with the anesthesiologists?
 21 A Which anesthesiologists?
 22 Q Well, you said that you would have --
 23 that you would have discussions from time to time
 24 with anesthesiologists about their use of the

Page 95

1 Q Well, you said that you -- I'm trying
 2 to get a -- the context of the term gatekeeper.
 3 You said, of course, you've heard the terms.
 4 We've all heard the term, but what I'm asking is
 5 whether that term is something that's come up in
 6 the context of administering the CRNA program?
 7 A Not to my recollection, no.
 8 Q In the functioning of the CRNA
 9 program, have you heard that term used,
 10 gatekeeper?
 11 MR. LAND: Object as asked and answered.
 12 BY MS. SIEGEL:
 13 Q Now, I was talking -- speaking more
 14 generally the functioning of the CRNA program?
 15 MR. LAND: That's what you asked him before.
 16 THE WITNESS: Not that I -- no.
 17 BY MS. SIEGEL:
 18 Q All right. Is there anything that you
 19 do to calibrate, I guess you would say, the CRNA
 20 evaluations of the SRNAs?
 21 MR. LAND: Object as vague.
 22 THE WITNESS: I don't understand the use of
 23 calibrate.
 24

Page 97

1 evaluation tool?
 2 A I don't believe I said that.
 3 Q All right. Did you have any sort of
 4 discussion about the -- about misuse of the
 5 Likert scale?
 6 A I didn't characterize it as a misuse.
 7 MR. LAND: Objection, vague.
 8 BY MS. SIEGEL:
 9 Q All right. So there was -- Strike
 10 that.
 11 Is that an appropriate use of the
 12 Likert scale to circle all of the ratings for all
 13 the criteria -- that doesn't make sense. To take
 14 -- to circle as a group the ratings for the
 15 various criteria?
 16 MR. LAND: Object to form of the question.
 17 It's vague, compound.
 18 BY MS. SIEGEL:
 19 Q I'm referring -- just to clarify the
 20 question a little bit, I'm referring to your
 21 testimony about how some people would, for
 22 example, make a circle around all of the
 23 outstanding ratings for a given student?
 24 A If that's what they truly believe,

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 98

1 they're, you know, that's their prerogative to
2 make those ratings; but when it comes to
3 interrater reliability, you know, it doesn't
4 always dive -- there may not be a correlation
5 between one of these evaluations that just choses
6 all five's and no comments versus, you know, a
7 bit of variation in numeric ratings with some
8 more specific comments about the student's
9 performance.
10 Q And what I'm asking is if you take
11 steps to try to assure that kind of interrater
12 reliability?
13 A I don't know what steps I could take
14 to insure that, you know, 30 plus
15 anesthesiologists and 30 nurse anesthetists have
16 -- are viewing student -- are evaluating student
17 performance similarly.
18 Q Is there anything that you do to
19 control for bias on the ratings?
20 A That's assuming that there is bias in
21 ratings.
22 Q No, I'm asking if you do anything to
23 control for it? It doesn't necessarily assume
24 there is any.

Page 99

1 MR. LAND: I would object to the form
2 because you're arguing, so it's argumentative.
3 MS. SIEGEL: He asked for clarification, I
4 provided it.
5 MR. LAND: What's the question?
6 (Record read by the reporter as
7 follows:
8 "Q Is there anything that you
9 do to control for bias on the
10 ratings?")
11 BY MS. SIEGEL:
12 Q Can you answer?
13 A Is it the same question?
14 Q I'm asking whether you do anything to
15 control with reference to bias in connection with
16 the evaluation ratings?
17 MR. LAND: Just object as asked and answered
18 and vague.
19 THE WITNESS: I'm not aware of intentional
20 bias in ratings.
21 BY MS. SIEGEL:
22 Q Do you do anything with evaluations to
23 see if there are patterns that would reflect
24 intentional bias in ratings?

Page 100

1 A You look at the evaluations
2 individually and in the aggregate. If there was
3 a concerning trend of some kind, there would be
4 follow up with the involved provider as well as
5 clinical leadership and we've done that.
6 Q Did you do that in the 2013-2014
7 academic years?
8 A I don't recall.
9 Q What do you do when you receive a
10 complaint about a given evaluation as to its
11 accuracy?
12 A A complaint from whom?
13 Q Anybody?
14 A I'm not following.
15 Q Do you ever get complaints about
16 evaluations as to their accuracy? By evaluations
17 I'm referring to the CRNA evaluations of the
18 performance of SRNAs in a given procedure?
19 A Rarely.
20 Q What do you do when you receive one?
21 A When I receive complaints?
22 Q When you receive complaints, that's
23 right?
24 A I would discuss it with the involved

Page 101

1 -- with the complainant. I would look at the
2 trends, the performance trends, to see if the
3 evaluation in question is an outlier or
4 reflective of performance trends.
5 Q Do you do anything else?
6 A It would depend on the situation, but
7 I would follow up if I thought it was warranted
8 with the evaluator just to get some additional
9 clarity on the basis for the contested
10 evaluation.
11 Q What does it -- Strike that.
12 What ratings must a student receive,
13 an SRNA, in order to have a satisfactory
14 evaluation?
15 A They're most likely to -- Well, let me
16 back up. Can you restate the question?
17 (Record read by the reporter.)
18 THE WITNESS: Are we talking about a
19 formative clinical evaluation?
20 BY MS. SIEGEL:
21 Q A formative clinical evaluation,
22 that's right.
23 A So they would need to meet or exceed
24 the elements under each domain on the evaluation

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 102

1 tool. If they're unsatisfactory ratings in areas
2 that impact patient safety, then that would be
3 considered an unsatisfactory evaluation.
4 Q Let's take a look again at Rush
5 Exhibit -- I'm sorry. Plaintiff's Exhibit 12.
6 Do you have that there?
7 MR. LAND: The only thing that's marked
8 Exhibit 12 the one that you didn't ask him about.
9 THE WITNESS: Oh, not Bates number, but
10 Exhibit 12?
11 BY MS. SIEGEL:
12 Q I am handing you what's previously
13 been marked as Plaintiff's Exhibit 8. And this
14 is an example of a formative SRNA evaluation,
15 isn't it?
16 A Yes, it is.
17 Q Of clinical performance?
18 A Yes, it is.
19 Q And can you tell me which are the
20 domains that involve ratings of patient safety?
21 A Well, there is domain 1A through C,
22 impact patient safety. And we've changed tools
23 so that's why it's taking me a minute to --
24 Q When did you change tools?

Page 104

1 A I would talk to them and talk to the
2 clinical instructor as well to hear the
3 instructor's basis for rating the student as they
4 did and to hear what the student had to say about
5 the case.
6 Q And if the student made the case that
7 there were some inaccuracy in their evaluation,
8 would that affect the formative evaluation for
9 the student for that day?
10 MR. LAND: Object as vague.
11 THE WITNESS: I don't understand the
12 question.
13 BY MS. SIEGEL:
14 Q All right. Let's take a hypothetical.
15 If a student came in and said that there were
16 something inaccurate about the -- about an
17 unsatisfactory rating that they had been given
18 and you spoke with the clinical instructor and
19 spoke with the student and determined that the
20 student were right, would that be reflected in
21 any way in the -- in the formative evaluation?
22 MR. LAND: Just object as calling for
23 speculation, but you can answer if you can.
24 THE WITNESS: It may be, but it's rare that

Page 103

1 MR. LAND: Can he please answer the first
2 question.
3 THE WITNESS: It's primarily the elements
4 under patient safety and clinical judgment.
5 BY MS. SIEGEL:
6 Q Anything else?
7 A There may have been. This is an older
8 tool. So we changed the tool a couple of years
9 ago.
10 Q You changed it in 2016?
11 A Approximately, yes.
12 Q And the form that we're looking at
13 here in Plaintiff's Exhibit 8 is the form that
14 was used in 2013 and 2014; is that right?
15 A Yes.
16 Q Okay. So all right. And if somebody
17 had an unsatisfactory rating in one of those two
18 domains, domain one and domain three; then that
19 would be an unsatisfactory overall evaluation?
20 A Uh-huh.
21 Q Yes?
22 A Yes.
23 Q Now, when a student got an
24 unsatisfactory evaluation, what would happen?

Page 105

1 a student disputes the feedback on a formative
2 evaluation.
3 BY MS. SIEGEL:
4 Q All right. In the event that a
5 student disputed the evaluation and you
6 determined that the student were correct, that
7 there was an inaccuracy; would you do anything
8 about the formative evaluation?
9 MR. LAND: Just object as vague, asked and
10 answered.
11 THE WITNESS: The formative evaluation is
12 part of the student's file. It would remain part
13 of the student's file.
14 BY MS. SIEGEL:
15 Q Would it be reflected in any way with
16 the summative evaluation that the student
17 ultimately received?
18 A It would.
19 Q And how would the inaccurate
20 evaluation be treated in the context of the
21 summative evaluation?
22 MR. LAND: Just object as mischaracterizing
23 his testimony.
24 THE WITNESS: I don't understand how an

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 106

1 evaluation would be determined to be inaccurate.
 2 BY MS. SIEGEL:
 3 Q All right. Have you ever determined
 4 that there was an -- that there was a formative
 5 evaluation that was inaccurate?
 6 MR. LAND: Just object as vague.
 7 BY MS. SIEGEL:
 8 Q You can answer.
 9 A I would say there are situations where
 10 perceptions vary, but I wouldn't call a -- the
 11 fact that a student disagrees with how they have
 12 been evaluated as automatically characterizing
 13 that evaluation as inaccurate.
 14 Q Well, if a student disagreed with an
 15 evaluation and you investigated, you described
 16 how you investigated it. And you made a
 17 determination that there was an inaccuracy, would
 18 that be reflected in some way in the summative
 19 evaluation for that student for that -- for that
 20 term?
 21 A When I write summative evaluations I
 22 have excerpts of the feedback from clinical
 23 instructors. There is a space for student
 24 comments. So students can write rebuttals if

Page 107

1 they choose to and that's how it's handled.
 2 Q But the original formative evaluation
 3 stands as written?
 4 A Yes, it does.
 5 MS. SIEGEL: Time to break for lunch?
 6 MR. LAND: Yes.
 7 (Whereupon a recess was taken
 8 at 12:31 p.m. and the
 9 deposition resumed at 1:25
 10 p.m.)
 11 BY MS. SIEGEL:
 12 Q Dr. Kremer, who is Eva Fisher?
 13 A She's a nurse anesthetist.
 14 Q And do you know where she is employed
 15 at this time?
 16 A I believe she's employed in the
 17 NorthShore HealthSystem.
 18 Q And during the time that Miss Marcial
 19 was enrolled in the CRNA program at Rush was Miss
 20 Fisher a CRNA on the Rush staff?
 21 A Yes, she was.
 22 Q And going to -- Did you ever speak
 23 with Miss Fisher?
 24 A Yes I've spoken with Miss Fisher.

Page 108

1 Q About Miss Marcial?
 2 A I don't recall.
 3 Q Okay. I am going to hand you --
 4 MS. SIEGEL: Off the record.
 5 (Discussion outside the
 6 record.)
 7 BY MS. SIEGEL:
 8 Q Dr. Kremer, the -- we've been talking
 9 about Miss Wimberly's evaluation of Miss Marcial
 10 on June 20th of 2013. And I am going to hand you
 11 what's previously been marked as Plaintiff's
 12 Exhibit 2. I'm going to ask if you recognize
 13 that document?
 14 MR. LAND: I just want to clarify before you
 15 answer. I don't think we've talked about this
 16 day or this evaluation yet.
 17 MS. SIEGEL: All right. That's fine.
 18 MR. LAND: Go ahead. Do you recognize that?
 19 THE WITNESS: I recognize it.
 20 BY MS. SIEGEL:
 21 Q Can you tell me what it is, please?
 22 A It's a formative evaluation.
 23 Q And when did this evaluation come to
 24 your attention?

Page 109

1 A I don't recall.
 2 Q It's dated June 20th of 2013; is that
 3 right?
 4 A It is.
 5 Q And you recognize Miss Wimberly's
 6 signature?
 7 A I see her name written there. I've
 8 seen her use other signatures, but I believe it's
 9 her's.
 10 Q Okay. And did you see this document
 11 on or about June 20th, 2013?
 12 A Very likely, yes.
 13 Q Now, there was a dispute over this
 14 evaluation, wasn't there?
 15 A Who was disputing the evaluation?
 16 Q Are you aware of a dispute over this
 17 evaluation?
 18 A Not without further clarification.
 19 Q Did anyone dispute this evaluation to
 20 you?
 21 A How do you mean dispute?
 22 Q Did anyone suggest the aspects, some
 23 or all, of this evaluation were inaccurate?
 24 A That may have been Miss Marcial's

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 110

Page 111

1 perception.
 2 Q And when did -- when did that --
 3 Strike that.
 4 Is it your testimony that it was not
 5 Miss Marcial's perception that this evaluation
 6 was inaccurate in respects?
 7 A Can you repeat the question?
 8 (Record read by the reporter.)
 9 THE WITNESS: There are two negatives in
 10 there. I'm --
 11 BY MS. SIEGEL:
 12 Q Is it your testimony that Miss Marcial
 13 did not perceive Plaintiff's Exhibit 2 to have
 14 inaccuracies?
 15 MR. LAND: Object as asked and answered.
 16 BY MS. SIEGEL:
 17 Q You may answer.
 18 A I believe I stated that Miss Marcial
 19 perceived that there were aspects of the
 20 evaluation that weren't accurate.
 21 Q And did she come to your office some
 22 time on or around June 20th of 2013 to discuss
 23 this -- to discuss her session with Miss
 24 Wimberly?

1 A What is the session you are referring
 2 to?
 3 Q Her June 20th, 2013, session with Miss
 4 Wimberly?
 5 A I don't understand the meaning of
 6 session.
 7 Q I'll rephrase the question. Did Miss
 8 Marcial come to your office to discuss her
 9 procedure with Miss Wimberly on June 20th of
 10 2013?
 11 A Miss Marcial came to my office and
 12 said that she had been dismissed from the
 13 operating room. And it took a while to formulate
 14 a timeline of the events that she was relating,
 15 but she said that Miss Wimberly had concerns
 16 about her level of preparation for her assigned
 17 cases.
 18 Q And you prepared a timeline?
 19 A I constructed a timeline as we spoke.
 20 Not a written timeline, but Miss Marcial was
 21 upset and I was just trying to understand what
 22 had transpired in the operating room that morning
 23 before she left.
 24 Q What time did Miss Marcial come to

Page 112

Page 113

1 your office?
 2 A I believe it was late morning.
 3 Q As you tried to construct the
 4 timeline, did you note the time of day that she
 5 appeared?
 6 MR. LAND: Just object as mischaracterizing
 7 his testimony about constructing a timeline.
 8 BY MS. SIEGEL:
 9 Q You may answer.
 10 A I believe she came to see me late that
 11 morning.
 12 Q You didn't note a specific time that
 13 she came?
 14 A No.
 15 Q All right. And when she came what did
 16 she say to you?
 17 A Well, it was kind of a jumble because
 18 she was upset and she -- all I can remember this
 19 far from the incident is that her instructor was
 20 concerned that -- her instructor believed that
 21 she wasn't adequately prepared for her assigned
 22 cases. And there were some other things that
 23 happened during the case specific to patient
 24 management that led to Miss Marcial being

1 dismissed from the OR.
 2 Q If you look down at professionalism,
 3 it's section 4A, Roman numeral 4A of the
 4 evaluation form. It says, that she is rated
 5 unsatisfactory for promptness and attendance and
 6 it states that she, quote, "Left OR without
 7 telling CRNA or attending". Do you see that?
 8 A I do.
 9 Q Now, Miss Marcial had told you that
 10 she was dismissed from the OR. Did that jive
 11 with the allegation that she left the OR without
 12 telling the CRNA or the attending?
 13 A I wasn't in the OR. I don't know what
 14 transpired. But while she was relieved of her
 15 clinical responsibilities, it was her decision to
 16 leave the operating room and not to inform the
 17 clinical coordinator that she was leaving the
 18 operating room.
 19 Q And what's the basis for you -- for
 20 your testimony that it was Miss Marcial's
 21 decision to leave the OR without informing the
 22 CRNA?
 23 A Because what's documented is that she
 24 left the operating room without telling a CRNA or

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 114

1 the attending anesthesiologist. And when I spoke
2 to Mr. Narbone, he wasn't aware that she had left
3 the operating room.
4 Q When did you speak to Mr. Narbone?
5 A Sometime after I spoke with Miss
6 Marcial.
7 Q Had he spoken with Miss Marcial at
8 that time?
9 A Not that I know of.
10 Q Now, what Miss Marcial said was that
11 she had been dismissed from the OR; does that not
12 indicate that she should leave the OR?
13 A She was dismissed from the case. It's
14 different than physically leaving the operating
15 room suite.
16 Q Did Miss Marcial tell you that she had
17 been directed to see you?
18 A I don't recall.
19 Q And what else did Miss Marcial tell
20 you when she came into your office?
21 A She said she was very well prepared
22 for her assigned case or cases. And on her
23 clipboard she had a hard copy of a template that
24 I believe was available online that could be

Page 115

1 populated with drug doses, fluid management,
2 ventilator management settings, airway equipment
3 sizes. And there was that sheet and then there
4 were several Post-it notes attached to the sheet
5 that she referred to as her preps. And she said
6 she had done her preps on the patients.
7 Q How many pages were there?
8 A I don't know. I just saw the page
9 that was the template from the online source.
10 Q Did you review the material she showed
11 you?
12 A I saw it. I didn't closely
13 investigate it.
14 Q Did you make a determination that her
15 preparations were inadequate?
16 A There was documentation that her
17 preparation was inadequate from her clinical
18 instructor.
19 Q And you're referring to the
20 unsatisfactory rating that Miss Wimberly gave her
21 on the room preparation?
22 A Among other things, yes.
23 Q Well, and what else?
24 A Entering adult doses for postoperative

Page 116

1 narcotic administration.
2 Q And where did you see that?
3 A It was described in the narrative.
4 Q All right. That's the second page of
5 the exhibit?
6 A That's the second page of the exhibit.
7 Q And can you tell us what you are
8 referring to on that second page?
9 A The final paragraph.
10 Q And what specifically are you
11 referring to, Doctor?
12 A "She needed to chart and look up
13 dosing, etcetera. When I asked her to tell me
14 how to properly dose opioids, emergency drugs,
15 etcetera, she could not do so".
16 Q What are you referring to and where is
17 it, please, on the page?
18 A It's Rush 21, the third paragraph.
19 Q What line?
20 A There aren't identified lines.
21 Q Well, is it the first line in the
22 paragraph?
23 A The third line. Oh, and the paragraph
24 above the second paragraph goes into detail about

Page 117

1 the ordering of opioids for the pediatric
2 patient.
3 Q Can you tell us, please, what the
4 correct answer would be to that question about
5 the dosing for Tylenol of a child with this type
6 of procedure?
7 A The dosing of Tylenol?
8 Q Yes.
9 A People -- depends on the route.
10 Depends on the overall health status of the
11 child.
12 Q So the amount of Tylenol dosage could
13 vary?
14 A It could.
15 Q And then there's also a discussion
16 here of the dosing of fentanyl?
17 A Yes.
18 Q And what is the correct dosage --
19 Strike that.
20 Can you tell us what the answer would
21 be to the question as to what the correct dosage
22 of fentanyl would be?
23 A It would be whatever was in the
24 pediatric order set and weight based.

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 118

Page 119

1 Q I'm sorry, your voice dropped.
 2 Whatever was in the pediatrics order?
 3 A Order set.
 4 Q And where would the pediatrics order
 5 set be found?
 6 A In the electronic medical record.
 7 Q Who would have entered the pediatric
 8 order into the medical record?
 9 MR. LAND: Objection, calls for speculation.
 10 THE WITNESS: I don't know.
 11 BY MS. SIEGEL:
 12 Q Well, would that have been the surgeon
 13 that was performing the procedure?
 14 A There is standard order sets in EPIC
 15 and other electronic medical systems. And those
 16 order sets are formulated by usually committees
 17 of clinical experts from the relevant
 18 disciplines.
 19 Q So is there a specific number that
 20 sitting here today you would be able to give?
 21 A I am not a pediatric anesthesia
 22 expert.
 23 Q All right. And was there any other
 24 issue that was discussed that day with Miss

1 Marcial regarding Plaintiff's Exhibit 2?
 2 A I am not sure at what time Plaintiff's
 3 Exhibit 2 came into my possession.
 4 Q Was there anything else that you
 5 recall in your meeting on June 20th of 2013 with
 6 Miss Marcial, what issues she may have raised?
 7 A I just remember that she was upset and
 8 that I believe she returned eventually to the OR
 9 and that Mr. Narbone sent her home for the day.
 10 Q Now, you say that Miss Marcial was
 11 upset, did she describe Miss Wimberly's behavior
 12 in the OR on June 20th?
 13 A I don't recall.
 14 Q Do you recall hearing anything about
 15 how she was -- how Miss Wimberly was upset and
 16 was slamming syringes and drawers in the OR?
 17 A I don't recall hearing that.
 18 Q Did Miss Marcial communicate to you
 19 that Miss Wimberly had lost her composure?
 20 A I don't remember hearing that phrase
 21 used.
 22 Q Do you recall hearing anything that
 23 would communicate to you that Miss Wimberly had
 24 lost her composure on June 20th in the OR?

Page 120

Page 121

1 A It sounded like Miss Wimberly was
 2 upset about how things were going.
 3 Q Do you recall anything else about your
 4 meeting with Miss Marcial on June 20th?
 5 A No.
 6 Q Did you subsequently have a discussion
 7 with Miss Wimberly?
 8 A I very likely did, yes.
 9 Q And I'm talking about this June 20th
 10 procedure with -- that Miss Marcial assisted
 11 with?
 12 A Uh-huh.
 13 Q Okay. Do you recall anything about
 14 your discussion with Miss Wimberly regarding the
 15 June 20th, 2013, procedure?
 16 A I have a general recollection that she
 17 confirmed the -- she confirmed the substance of
 18 what was in the evaluation when we spoke.
 19 Q And is it -- is it your recollection
 20 that that meeting with Miss Wimberly occurred
 21 after Miss Wimberly had drafted Plaintiff's
 22 Exhibit 2?
 23 A I have no idea.
 24 Q Now, is it correct that CRNA clinical

1 instructor evaluations are forwarded to Mr.
 2 Narbone?
 3 A That's been my practice. When he was
 4 in that position and I was in the program
 5 director position.
 6 Q And did you send them to him after you
 7 initially reviewed them?
 8 A Yes.
 9 Q And was it the case that he received
 10 copies of all evaluations?
 11 A All evaluations of whom?
 12 Q SRNAs?
 13 A Of SRNAs?
 14 Q SRNAs by the CRNAs?
 15 A Did Mr. Narbone receive evaluations of
 16 the SRNAs by the CRNAs?
 17 Q I'll rephrase that. Did you forward
 18 to Mr. Narbone copies of the evaluations prepared
 19 by CRNAs of the SRNAs that they were supervising?
 20 A No, I didn't.
 21 Q Did he receive them by another means?
 22 A He didn't receive those evaluations
 23 because he was in the operating room every day
 24 and talking to the involved providers. So he

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 122

1 usually had a very good idea of what was going on
2 with the different trainees.
3 Q Did Miss Marcial communicate to you
4 around about June 20th of 2013 that she had been
5 told by another Filipino student that Miss
6 Wimberly had treated her in an abusive matter and
7 was on the warpath?
8 A I don't remember a conversation of
9 that nature.
10 Q Now, there was another Filipino
11 student in Miss Marcial's cohort, right?
12 A Yes.
13 Q And that was a student named Karen
14 Kam?
15 A Yes.
16 Q Did you have an opportunity to speak
17 with Miss Kam about Jill Wimberly?
18 A I don't recall.
19 Q Now, did you have a concern that Miss
20 Marcial had never purchased a copy of the text
21 that was used in the pediatrics anesthesia
22 course?
23 A I did when she revealed that to me
24 shortly before she came back into the clinical

Page 123

1 setting in January of 2014.
2 Q When did -- and what was the -- What
3 were the circumstances when she told you about
4 that?
5 A Completing a simulation exercise
6 involving a pediatric patient.
7 Q Do you recall what kind of procedure
8 it was?
9 A No, I just recall it was a pediatric
10 scenario and she struggled with pharmacology and
11 dosing of drugs.
12 Q And how did the issue of the textbook
13 come up?
14 A She volunteered that she hadn't
15 purchased it.
16 Q Did she tell you that she rented a
17 copy of the book?
18 A She may have said something to that
19 effect.
20 Q And did she tell you that she had --
21 that she worked with an e-copy of the text, an
22 e-book?
23 A Perhaps.
24 Q Have you examined the electronic

Page 124

1 version of the text that was used in the course?
2 A The electronic version of most texts
3 is -- has the same content that the print version
4 has.
5 Q And what was the text that was at
6 issue?
7 A Côté Anesthesia for Pediatrics or
8 something to that effect.
9 Q Was it required for the students to
10 purchase the hard copy?
11 A If I may, I would like to make it
12 clear that while there may not have been an
13 explicit requirement to purchase such books, it
14 would seem intuitive given that they will be
15 taking a comprehensive exam or a series of
16 comprehensive exams and that we're tasked with
17 educating nurse anesthetists who will be full
18 service licensed independent providers.
19 89 percent of the counties in the
20 state have nurse anesthetists practicing. In 29
21 percent of the counties they are the only
22 providers. So I think if it was your child or
23 your grandchild, you would want the anesthesia
24 provider to be fully versed in what was necessary

Page 125

1 to provide safe care.
2 Q And as for the electronic version of
3 the book, was there a requirement that the
4 student somehow use a hard copy, not an
5 electronic copy?
6 A There was no such requirement, but I
7 think it would be intuitive if one had struggled
8 with a content area, they would want to have a
9 reference readily at their fingertips that they
10 could easily refer to.
11 Q Dr. Kremer, I'm handing you what's
12 previously been marked as Plaintiff's Exhibit 4.
13 Have you ever seen a compilation such as
14 Plaintiff's Exhibit 4?
15 A I may have.
16 Q Could you describe for us, please,
17 what it is?
18 A Well, by the title it's an
19 anesthesiology pocket card set. So it's a
20 cognitive aid of some type.
21 Q Is this an aid that would make
22 anesthesiology information available at one's
23 fingertips for easy reference?
24 A If it was appropriately peer reviewed

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 126

1 and referenced. And there are situations that
 2 really don't permit time for looking up and
 3 calculating doses if someone's life is at stake.
 4 Q And as a form of reference, is this
 5 something that would appear to you to be useful?
 6 A It appears that it could be useful.
 7 Q And I am handing you now what's
 8 previously been marked as Plaintiff's Exhibit 5.
 9 A Okay.
 10 Q Sorry, I didn't mean to leave that in
 11 the middle of the table. Can you tell me what
 12 that is, please?
 13 A It's titled the pediatric anesthesia
 14 worksheet.
 15 Q Have you seen a document like that
 16 before?
 17 A I may have.
 18 Q Okay. And are Plaintiff's Exhibit 4
 19 and Plaintiff's Exhibit 5 appropriate materials
 20 for assisting SRNAs in mastering dosages and
 21 double checking their recollection of dosages?
 22 MR. LAND: Object to the form of the
 23 question as vague.
 24

Page 128

1 referenced and highlighted and is there in its
 2 entirety as opposed to selectively printing out
 3 pages as you've described.
 4 Q Can one highlight an electronic copy
 5 of the book?
 6 A I suppose. It depends on the format.
 7 Q Did you ever look at the electronic
 8 version of the Coté text?
 9 A I have had no occasion to.
 10 Q There was an issue on June 20th about
 11 whether Miss Wimberly had paged Miss -- I'm
 12 sorry, whether -- that's right. Whether Miss --
 13 Let me start again.
 14 There was an issue on June 20th of
 15 2013 as to whether Miss Wimberly had paged Miss
 16 Marcial that morning; do you recall?
 17 A I recall a discussion about that
 18 topic, yes.
 19 Q And Miss Wimberly represented that she
 20 had paged Miss Marcial; isn't that right?
 21 A I believe so.
 22 Q And Miss Marcial disputed whether or
 23 not she had received the page; is that right?
 24 A That's correct.

Page 127

1 BY MS. SIEGEL:
 2 Q You may answer.
 3 A These aren't sources that are used in
 4 our program. I can't comment on their validity
 5 or reliability.
 6 Q Now, would it be your understanding
 7 that an electronic book -- portions of an
 8 electronic book could be printed out for ready
 9 reference?
 10 A Of course.
 11 Q And would that have certain
 12 portability advantages over hard copy, a hard
 13 copy text?
 14 A Well, I mean, a digital text could be
 15 on a tablet or say a smart phone. So, I mean,
 16 I'm not sure how portability -- the context we're
 17 discussing the portability.
 18 Q Well, if the -- if there were an
 19 electronic version of the Coté text that you've
 20 discussed. And is there anything about that,
 21 that version of the book, that is inferior to
 22 having the hard copy?
 23 A I don't think it is the same advantage
 24 as having a hard copy that can be readily

Page 129

1 Q And Miss Marcial showed you her pager,
 2 didn't she, on June 20th?
 3 A She showed me a pager, yes.
 4 Q Did you think it wasn't perhaps Miss
 5 Marcial's pager?
 6 A I have no way of knowing.
 7 Q When she showed it to you, did you
 8 think she was showing you somebody else's pager?
 9 A I have no way of knowing if it was
 10 Miss Marcial's pager when it had been turned on.
 11 Q Did you check out Miss Wimberly's
 12 pager to see if in fact she transmitted a page?
 13 A She wouldn't transmit a page from her
 14 pager.
 15 Q All right. How would she do that?
 16 A From a computer workstation.
 17 Q Did you check out the computer
 18 workstation to see if Miss Wimberly had in fact
 19 paged Miss Marcial?
 20 A No, I did not.
 21 Q Did you believe that Miss Marcial had
 22 failed to respond to a page?
 23 A All I knew was that there was -- I
 24 believe there was a delay in a case being

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 130

1 started, in a case being moved to another room.
2 And for whatever reason Miss Marcial wasn't aware
3 of that.

4 Q Did you discuss that with Miss
5 Wimberly?

6 A I probably did.

7 Q And was that around June 20th of 2013?

8 A It likely was.

9 Q Was that part of the conversation that
10 you had -- was it in your office?

11 A I don't recall.

12 Q Do you remember what you said to her
13 and what she said to you?

14 A I do not.

15 Q Now, didn't -- looking back at
16 Plaintiff's Exhibit 2, didn't Miss Wimberly base
17 her unsatisfactory rating on professionalism in
18 part on Miss Marcial's alleged failure to answer
19 her page? I'm looking at the bottom of the first
20 page of Plaintiff's Exhibit 2.

21 A Yes.

22 Q Did you think that Miss Marcial was
23 not telling the truth about the alleged failure
24 to answer her page?

Page 131

1 A It was very clear that there was a
2 communication problem. The genesis of that
3 problem was not readily apparent.

4 Q Well, was that -- was that apparent
5 communication problem, could that have been
6 attributable to Miss -- strike that, Miss
7 Wimberly's failure to page Miss Marcial?

8 A It could have been.

9 Q And could Miss Wimberly have falsely
10 attributed her own failure to Miss Marcial?

11 A I don't know.

12 Q Would it concern you if a CRNA falsely
13 reported making a page that in fact hadn't been
14 made?

15 A I'm a lot more concerned about things
16 like inappropriate drug doses and lack of
17 preparation compared to communication issues with
18 pagers.

19 Q Did it concern you that there was
20 possibly a misrepresentation of the specific
21 issue of paging? Did it concern you that other
22 representations in the document may not have been
23 truthful?

24 MR. LAND: Object as mischaracterizing his

Page 132

1 testimony and to the form of the question as
2 vague and compound.

3 BY MS. SIEGEL:

4 Q Did you understand my question?

5 A Can you repeat it, please.

6 (Record read by the reporter as
7 follows:

8 "Q Did it concern you that
9 there was possibly a
10 misrepresentation of the
11 specific issue of paging? Did
12 it concern you that other
13 representations in the
14 document may not have been
15 truthful?")

16 THE WITNESS: I spoke with Dr. Brian Myers
17 the attending anesthesiologist the day after this
18 incident, and he largely corroborated what Miss
19 Wimberly reported in terms of clinical issues.
20 And those were of higher priority to me than the
21 paging issues.

22 BY MS. SIEGEL:

23 Q And where did you speak with Mr.
24 Myers?

Page 133

1 A Dr. Myers.

2 Q Where did you speak with Dr. Myers?

3 A In the operating room.

4 Q Was anyone else present?

5 A I don't think so.

6 Q What did he say to you and what did
7 you say to him?

8 A I don't remember the exact
9 conversation.

10 Q Do you remember what he corroborated?

11 A He corroborated that there were
12 concerns about the student's level of preparation
13 and putting in appropriate post-op analgesic
14 orders.

15 Q Did he tell you anything more specific
16 about the postoperative drug orders?

17 A I don't recall.

18 Q Was Dr. Myers present for the entire
19 case?

20 A The nature of that anesthesia practice
21 is that the attending anesthesiologists are in
22 and out of the room. To maintain compliance with
23 building requirements, they have to be present at
24 the beginning and the end of the case as well as

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 134

Page 135

1 at critical intervals during the case.
 2 Q Would that -- Would his moving in and
 3 out of the room affected his ability to observe
 4 the circumstances of the postoperative drug
 5 orders?
 6 MR. LAND: Objection, calls for speculation.
 7 THE WITNESS: It may have.
 8 BY MS. SIEGEL:
 9 Q Is that something that you looked into
 10 to determine whether or not that affected his
 11 perception of what had occurred?
 12 A I didn't ask the doctor in detail what
 13 impacted his perception of the events.
 14 Q Okay. Now, is it not correct that
 15 Miss Marcial contacted an attending
 16 anesthesiologist at Rush regarding the pediatric
 17 dosing guidelines?
 18 MR. LAND: Can you read that back?
 19 (Record read by the reporter.)
 20 MR. LAND: Objection is foundation.
 21 THE WITNESS: I am not aware of an attending
 22 anesthesiologist at Rush who she contacted.
 23 BY MS. SIEGEL:
 24 Q Was there an anesthesiologist who had

1 at one time been affiliated with Rush that she
 2 contacted to your knowledge?
 3 A That may have been the case. I don't
 4 know what information that individual was given.
 5 Q Now, when you say that you don't know
 6 the information that the individual was given,
 7 can you be more specific as to what you were
 8 referring to?
 9 A What I'm referring to is that dosing
 10 of opioids for open heart surgery versus
 11 postoperative analgesia is significantly
 12 different. There is a wide range of what
 13 acceptable doses may constitute. And as I said
 14 earlier also based on weight and patient acuity,
 15 those factors also determine appropriate dosing
 16 for pediatric patients.
 17 Q And did the -- Strike that.
 18 Did Dr. Myers express a specific dose
 19 that he had -- that he had indicated?
 20 A Not that I recall.
 21 Q Did Miss Wimberly indicate to you a
 22 specific dose that she felt that the patient
 23 should have?
 24 A I think her concern was use of the

Page 136

Page 137

1 adult postoperative analgesia order set versus
 2 the pediatric postoperative analgesia post order
 3 set.
 4 Q Is it your understanding -- Strike
 5 that.
 6 Is it your recollection that it was 20
 7 minutes into your discussion with Miss Marcial on
 8 June 20th that she told you that she had left the
 9 OR without telling somebody?
 10 A I don't recall.
 11 Q Did you take notes of your discussion
 12 with Miss Marcial that day?
 13 A I don't recall. If I did they would
 14 be in her file.
 15 Q Subsequently did it come to your
 16 attention that Miss Marcial had been told of an
 17 incident where Miss Wimberly was speaking on the
 18 phone in some kind of break room within hearing
 19 of patients and nurses and other medical staff
 20 and loudly said, my student just tried to
 21 overdose a patient.
 22 A Can you repeat the question.
 23 (Record read by the reporter.)
 24 THE WITNESS: I don't recall.

1 BY MS. SIEGEL:
 2 Q Would it concern you if a CRNA made a
 3 loud statement that was within hearing of
 4 patients and nurses and other medical staff that
 5 a student had tried to overdose a patient?
 6 MR. LAND: Objection, calls for speculation.
 7 MS. SIEGEL: He can answer as to his -- as
 8 to whether that would concern him.
 9 MR. LAND: In any circumstance regardless of
 10 what happened? That's why I'm objecting.
 11 BY MS. SIEGEL:
 12 Q You may answer.
 13 A I'm thinking. It's a very unlikely
 14 scenario.
 15 Q Why is that unlikely?
 16 A It's not consistent with the behavior
 17 of the people I know and work with.
 18 Q Would that kind of inconsistent
 19 behavior be cause for concern?
 20 MR. LAND: Objection, calls for speculation
 21 and vague.
 22 THE WITNESS: I don't understand the
 23 question.
 24 MS. SIEGEL: Can we have it back, please?

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 138

1 (Record read by the reporter as
2 follows:
3 "Q Would that kind of
4 inconsistent behavior be cause
5 for concern?")
6 THE WITNESS: What's the inconsistent
7 behavior?
8 BY MS. SIEGEL:
9 Q Well, you've described we're talking
10 about a loud telephone conversation within
11 earshot of patients and other medical personnel
12 where there was a claim that an SRNA had tried to
13 overdose a patient.
14 And if I understand your testimony
15 it's that such a statement -- such a statement is
16 an unlikely scenario and not consistent with your
17 behavior norms at Rush?
18 A I didn't say that.
19 MR. LAND: I object to the characterization
20 of what you're talking about. You're talking
21 about a hypothetical question which calls for
22 speculation. You just defined it in a different
23 way than what he was talking about.
24

Page 139

1 BY MS. SIEGEL:
2 Q Can you answer that?
3 A No.
4 Q Are there behavioral expectations that
5 you have of CRNAs in the Rush -- in the Rush
6 anesthesia department?
7 A There are 10,000 employees at Rush.
8 We're held to the same standards in terms of
9 overall performance, expectations that we're
10 evaluated on in our annual review.
11 Q And professionalism is one of them,
12 right?
13 A Depends on the staff category.
14 Q Are CRNAs rated based on
15 professionalism?
16 A I don't complete evaluations on CRNAs.
17 Q I'm sorry?
18 A I don't complete evaluations on CRNAs.
19 Q Have you ever seen any?
20 A I have when I was a staff CRNA, but
21 the format has changed considerably since then.
22 Q In your opinion is it appropriate to
23 hold CRNAs to standards of professionalism?
24 A Yes, it is.

Page 140

1 Q And do you have an opinion as to
2 whether it's professional for a CRNA to speak
3 loudly on a telephone in the presence of other
4 people and say that an SRNA attempted to overdose
5 a patient?
6 A I know of no such scenario.
7 Q And if I've asked this before, I
8 apologize; but it did not come to your attention
9 that such an accusation was leveled against Miss
10 Wimberly, is that right?
11 MR. LAND: You did ask and he answered that
12 question before, so I object.
13 THE WITNESS: I don't understand the
14 question. What accusation?
15 BY MS. SIEGEL:
16 Q All right. Let's try this, did anyone
17 tell you that that happened?
18 A That what happened?
19 Q That Miss Wimberly was on the phone
20 and loudly said that an SRNA tried to overdose a
21 patient?
22 A I didn't hear any statement like that
23 from anyone who was a witness to such an event.
24 Q Did you hear indirectly that someone

Page 141

1 had overheard that statement?
2 A I don't recall.
3 MS. SIEGEL: Why don't we take five minutes
4 here.
5 (Whereupon a recess was taken
6 at 2:23 p.m. and the
7 deposition resumed at 2:38
8 p.m.)
9 BY MS. SIEGEL:
10 Q How many unsatisfactory evaluations in
11 the area of patient safety may a CRNA get before
12 she's in or he is in danger of failure?
13 A We don't evaluate CRNAs.
14 Q You are exactly right. How many
15 unsatisfactory evaluations may an SRNA receive
16 before they're in danger of failing?
17 A Our program handbook says three.
18 Q Dr. Kremer, I'm handing you what's
19 previously been marked as Plaintiff's Exhibit 5.
20 And can you tell me what Plaintiff's Exhibit 5
21 is, please?
22 A It's a formative evaluation completed
23 by Eva Fisher on Maricel on June 11th of 2013.
24 Q That's for a procedure that occurred

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 142

1 on June 11th of 2013?
 2 A Appears to be, yes.
 3 Q And the -- is there a different date
 4 at the bottom of the page?
 5 A There is.
 6 Q And that would be June 18th of 2013;
 7 is that right?
 8 A Yes.
 9 Q And when did this evaluation come to
 10 your attention?
 11 A I don't know.
 12 Q Did you see it in the summer of 2013?
 13 A I would have seen it in the summer of
 14 2013, yes.
 15 Q Do you recall the circumstances?
 16 A I do not.
 17 Q And did Miss Marcial object to the --
 18 some of the evaluations she received in
 19 Plaintiff's Exhibit 5?
 20 A Yes.
 21 Q Did you have a meeting with Miss
 22 Marcial about it?
 23 A I believe we did, yes.
 24 Q Do you recall when that occurred?

Page 143

1 A Some time after the evaluation was
 2 submitted. I couldn't say exactly when.
 3 Q Do you have a recollection as to when
 4 the evaluation was submitted?
 5 A I have no idea when the evaluation was
 6 submitted.
 7 Q There is a place for the student
 8 signature and date; do you see that?
 9 A I do.
 10 Q And it's blank. Do you have an
 11 understanding as to why it would be blank?
 12 A I don't know for sure why it wasn't
 13 signed. Sometimes we have students come sign
 14 evaluations at the end of the term when we
 15 prepare their summative evaluation. It isn't
 16 always signed contemporaneously with receipt and
 17 review of the evaluation.
 18 Q And so you reviewed this evaluation
 19 with Miss Maricel?
 20 A Yes.
 21 Q And where did that occur?
 22 A Probably in my office.
 23 Q Did anyone else join you for that
 24 meeting?

Page 144

1 A I don't recall.
 2 Q And as well as you can recall today,
 3 what was said?
 4 A If I remember correctly Miss Marcial
 5 objected to the areas that were marked as
 6 unsatisfactory and said that they were -- I don't
 7 remember what her words were. I just had the
 8 impression that she felt that it was subjective
 9 and inaccurate feedback.
 10 Q You testified earlier that Miss Fisher
 11 is no longer at Rush?
 12 A That's right.
 13 Q And do you have any -- Do you have an
 14 understanding as to why she left Rush?
 15 A I think the clinical locations in the
 16 NorthShore system are closer to her home.
 17 Q Did she tell you that?
 18 A She may have.
 19 Q Was she asked to leave?
 20 A I don't believe so.
 21 Q You didn't ask her to leave?
 22 A Miss Fisher didn't report to me.
 23 Q Okay. You didn't have any discussion
 24 with her with -- regarding anyone asking her to

Page 145

1 leave?
 2 A No.
 3 Q Did Miss Marcial dispute that she
 4 prepared a wrong sized endotracheal tube for one
 5 of her patients during this procedure, these
 6 procedures?
 7 A As I recall her objection was that it
 8 was a subjective statement. And I asked is a
 9 wrong sized ETT for a child an objective
 10 statement.
 11 Q You asked her that?
 12 A I did.
 13 Q Did she answer you?
 14 A I believe she did.
 15 Q Do you recall what she said?
 16 A Not really, no.
 17 Q In a layout of instrumentation, would
 18 there only be one ETT tube laid out for a
 19 surgical procedure?
 20 A What we teach our trainees is to have
 21 the calculated endotracheal tube size prepared
 22 and styletted and have half a size smaller and
 23 half a size larger also available.
 24 Q So do I understand there would be at

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 146

1 least three sizes that would be available?
 2 A Depending on who prepared the airway
 3 equipment there could be.
 4 Q Could there be more than three?
 5 A There could be.
 6 Q Where does one get the airway
 7 equipment?
 8 A There is a pediatric anesthesia cart
 9 that has airway equipment and other pediatric
 10 specific equipment like blood pressure cuffs that
 11 are specific to pediatric patients.
 12 Q And where is the pediatrics cart
 13 located?
 14 A At Rush it's called the local room
 15 which is just their way of describing the
 16 anesthesia workroom. So I think -- well, I would
 17 be speculating. I don't know how many of them
 18 there are, but there are three different
 19 workrooms right now.
 20 Q So there's more than one workroom?
 21 A Yes, ma'am, that's right.
 22 Q It might not be the same three as now,
 23 but at the time there was more than one workroom?
 24 A I am just thinking back. Yes, at the

Page 147

1 time there was more than one workroom.
 2 Q And each one of those workrooms had a
 3 pediatric cart in it?
 4 A Very likely did, yes.
 5 Q Did you understand this criticism, the
 6 first one on room preparation and equipment
 7 check, that Miss Marcial had not put out a
 8 child-sized ETT tube?
 9 A That statement is wrong-sized ETT for
 10 child.
 11 Q Did you understand that to mean that
 12 she had put an adult tube out?
 13 A I understood that the instructor's
 14 statement is that it was the wrong-sized
 15 endotracheal tube. There is a wide range of
 16 endotracheal tube sizes that are used in
 17 pediatrics. So it could have been a pediatric
 18 tube or tubes that weren't the appropriate size
 19 for the patient or patients in question.
 20 Q Did you discuss that with Miss
 21 Marcial?
 22 A I may have.
 23 Q Do you have any recollection of it?
 24 A No.

Page 148

1 Q And did you have a discussion with
 2 Miss Marcial about an extubation after -- strike
 3 that, an extubation while the child was having
 4 apneic signs?
 5 A The concern was as written by Miss
 6 Fisher, "Took circuit off after extubation with
 7 baby having apneic spells".
 8 Q And did you discuss that with Miss
 9 Marcial?
 10 A Very likely.
 11 Q Do you recall what she said?
 12 A I probably asked what happened.
 13 Q Do you remember what she responded?
 14 A No, I don't.
 15 Q Do you recall what the problem was
 16 under clinical judgment with the fluids and
 17 hemotherapy calculation, initiation and
 18 management?
 19 A No, I don't.
 20 Q Did you follow up to find out what it
 21 was?
 22 A I very likely spoke to Miss Fisher.
 23 Q Do you recall what she told you?
 24 A I believe she corroborated what is

Page 149

1 documented in the evaluation.
 2 Q And did Miss Marcial agree with her
 3 unsatisfactory evaluation on that criterion?
 4 A Which criterion?
 5 Q The calculation, initiation and
 6 management of fluid and hemotherapy?
 7 A Well, she disputed the whole
 8 evaluation and said it was inaccurate.
 9 Q Do you recall specifically what she
 10 thought was inaccurate about it, Dr. Kremer?
 11 A The best recollection I have is that
 12 it was rejected and blocked as being inaccurate
 13 and unfair.
 14 Q Well, did you do anything to
 15 investigate that contention?
 16 A As I said I met with Miss Fisher.
 17 Q But you don't recall specifics as to
 18 what she said in support of her ratings?
 19 A As I said, she corroborated her
 20 ratings on the instrument.
 21 Q Well, do you recall what it was she
 22 said that was corroborative?
 23 A Not almost five years later, no, I
 24 don't.

Page 150

1 Q In June or July of 2013 did you have a
2 meeting with Miss Marcial and Dr. Wiley in which
3 you looked up fentanyl dosing in a text?
4 A I don't recall.
5 Q Is Amy Gawura still a CRNA at Rush?
6 A She's not.
7 Q Do you know where she is?
8 A She works in the NorthShore system.
9 Q Do you know why she went to
10 NorthShore?
11 A Her choice.
12 Q Do you know if she was asked to leave?
13 A I seriously doubt that. I don't know
14 for a fact since I don't manage the CRNAs.
15 Q That didn't come to your attention in
16 any event that she was asked to leave?
17 A I have no reason to believe that Amy
18 Gawura was asked to leave Rush.
19 Q And Katie Colino has also left?
20 A Some time ago.
21 Q Do you recall when she left?
22 A No, I don't.
23 Q Do you know where she went?
24 A When she left I believe she had taken

Page 151

1 a job at Condell Hospital in Libertyville. I
2 don't know if she is still working there.
3 Q Do you know why she left Rush?
4 A I think it -- Condell was closer to
5 home and she liked the schedule better.
6 Q Did you talk with her about it, did
7 she tell you that?
8 A We may have talked about it at the
9 time.
10 Q And who is Crystal Anderson?
11 A Crystal Anderson is a nurse
12 anesthetist who worked at Rush some years ago.
13 Q And is she there now?
14 A No, she's not.
15 Q And do you know what became of Crystal
16 Anderson?
17 A No, I don't.
18 Q Do you know where she is?
19 A Can you repeat the question?
20 Q Do you know where she is?
21 A No, I do not.
22 Q Did she stay in the field of
23 anesthesiology?
24 A I have no way of knowing that.

Page 152

1 Q Are you normally in the perioperative
2 area before cases begin?
3 A I make rounds on a regular basis.
4 Q And does that include the
5 perioperative area at the beginning of the day?
6 A It can.
7 Q Did you ever see Mr. Narbone there at
8 the beginning of the day?
9 A When he was employed there, yes.
10 Q Did you see him there frequently?
11 A Mr. Narbone basically lived at Rush.
12 He was probably there 80 hours a week.
13 Q And does that mean you would see him
14 in the perioperative area in the mornings before
15 things got going?
16 A Yes.
17 Q Okay. Did you have a joint meeting
18 with Miss Marcial and Dr. Wiley shortly after
19 Miss Fisher gave this evaluation for the June
20 11th procedure?
21 A Dr. Wiley and I met with Miss Marcial
22 on a number of occasions. We may have met
23 together some time after the June 11th evaluation
24 was completed.

Page 153

1 Q Would you have had occasion to discuss
2 both Miss Fisher's evaluation and Miss Wimberly's
3 evaluation with Miss Marcial in -- later in June
4 of 2013?
5 A That's likely, yes.
6 Q Meeting in your office?
7 A It could have been.
8 Q And what did you tell Miss Marcial?
9 A I don't recall.
10 Q Did you have a discussion with her
11 about her progress in the program?
12 A We probably discussed that, yes.
13 Q And as well as you can recall, what
14 did you advise her regarding her progress in the
15 program?
16 A I don't recall the substance of that
17 specific meeting.
18 Q Did you tell her she was in academic
19 jeopardy?
20 MR. LAND: Just object to the -- vague. I'm
21 not sure you've established what meeting you're
22 talking about. So I don't know if you're asking
23 about a specific meeting and a specific comment.
24 So object to the form.

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 154

1 BY MS. SIEGEL:
2 Q Well, after Miss Marcial received the
3 June 20th, 2013, evaluation from Miss Wimberly
4 and the June 18th evaluation from Miss Fisher;
5 did you get together with Miss Marcial and
6 Dr. Wiley to talk about Miss Marcial's
7 progression in light of those -- in light of
8 those two evaluations?
9 A Dr. Wiley and I had a number of
10 meetings with Miss Marcial over the summer of
11 2013.
12 Q Can you recall one in late June after
13 she had received the Fisher and the Wimberly
14 evaluations pretty much back to back?
15 A Not specifically, no.
16 Q Well, generally over the course of the
17 summer of 2013 how did you advise Miss Marcial
18 concerning her progression in the program?
19 A If I remember she accrued other
20 unsatisfactory evaluations. So we probably
21 talked about other options in terms of other
22 degree options that were available, but that
23 wasn't something she wanted to pursue.
24 Q What did you tell her about her

Page 155

1 prospects in the CRNA program?
2 A I don't specifically recall.
3 Q With reference to the Fisher and
4 Wimberly evaluations, those back-to-back
5 evaluations; did you tell Miss Marcial that there
6 were two strikes against her?
7 A I may have said something to that
8 effect.
9 Q As you sit here today do you believe
10 that Miss Marcial had two strikes against her at
11 that point?
12 A The reference was to two
13 unsatisfactory evaluations knowing that the third
14 would result in clinical failure.
15 Q Did you tell her that it would be a
16 herculean task to succeed in the program?
17 A I don't recall.
18 Q Did you tell her that her best
19 wouldn't be good enough?
20 A I really doubt I would have made a
21 statement like that.
22 Q Why not?
23 A It's not the way I typically talk to
24 students.

Page 156

1 Q Did you make a statement to that
2 effect?
3 A What's the question?
4 Q Did you make a statement to Miss
5 Marcial at the time of a meeting with Dr. Wiley
6 and yourself in approximately late June of 2013,
7 something to the effect that her best wouldn't be
8 good enough?
9 A I don't remember saying something to
10 the effect of her best wouldn't be good enough.
11 Q Did you perceive that she was doing
12 her best at that point?
13 A I couldn't say.
14 Q Did you make the statement when she
15 brought up issues of what she perceived to be
16 bias; did you make the statement who should I
17 believe, you or faculty?
18 MR. LAND: Object as to the form of the
19 question. Assuming facts not in evidence and
20 lack of foundation with the reference to bias.
21 You haven't asked him about a conversation about
22 bias.
23
24 BY MS. SIEGEL:

Page 157

1 Q Let me rephrase it. Miss Marcial had
2 stated that she felt that the evaluations by Miss
3 Fisher and Miss Wimberly were not accurate, isn't
4 that right?
5 A Yes.
6 Q And did she state with respect to Miss
7 Wimberly that she felt that certain statements
8 were false?
9 A I don't recall.
10 Q Did you ask her who should I believe,
11 you or faculty?
12 A I don't recall.
13 Q Why do you say that it's not the way
14 you talk to students with respect to your best
15 wouldn't be good enough?
16 A Because it's not the way I would
17 typically talk to a student.
18 Q What would you say?
19 MR. LAND: Object as hopelessly vague. What
20 would you say to students?
21 MS. SIEGEL: Right.
22 MR. LAND: That's too vague a question.
23 THE WITNESS: I have no context for that.
24 BY MS. SIEGEL:

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 158

1 Q If a student were experiencing
2 difficulty in the clinical context and you felt
3 that there was an issue with that student's
4 ability to perform, what would you say?
5 MR. LAND: Can you read that back, please.
6 (Record read by the reporter.)
7 MR. LAND: You're calling for speculation
8 and vague.
9 THE WITNESS: It would depend completely on
10 the student, their history up to that point,
11 anything else they might have disclosed about
12 stress or life events that they're experiencing.
13 BY MS. SIEGEL:
14 Q Do you recall Miss Marcial disclosing
15 anything in late June of 2013 with respect to
16 factors such as stress or life events that might
17 affect her ability to perform?
18 A Not at that time, no.
19 Q Do you recall anything that Dr. Wiley
20 said during that meeting?
21 A I do not.
22 Q How about Miss Marcial?
23 A Which meeting are you referencing?
24 Q Again, this meeting where you may have

Page 159

1 said something along the lines of you have two
2 strikes against you?
3 MR. LAND: You know, I object as
4 mischaracterizing his testimony. You asked about
5 meetings. He said he wasn't sure. Then you
6 asked questions about meetings over the entire
7 summer. Then you asked about specific comments.
8 Now you're asking about a meeting where something
9 was said. Lacks foundation and mischaracterizes
10 his testimony.
11 BY MS. SIEGEL:
12 Q Do you recall the question?
13 A Which date are we talking about?
14 MS. SIEGEL: Can you read the question back,
15 please.
16 (Record read by the reporter.)
17 THE WITNESS: I'm sorry, what's the
18 question?
19 (Record read by the reporter.)
20 BY MS. SIEGEL:
21 Q Let me direct your attention to a
22 meeting that you had with Dr. Wiley and Miss
23 Marcial after she had received -- after Miss
24 Marcial had received the evaluations from Eva

Page 160

1 Fisher and Jill Wimberly on approximately June
2 18th and June 20th of 2013.
3 A Is there a question?
4 Q Yes, did Miss Marcial indicate any
5 factors that might have affected her performance?
6 A Not at that time as I recall.
7 Q And as well as you can recall, did you
8 make any statement to Miss Marcial regarding her
9 prognosis for a successful completion of her CRNA
10 studies?
11 A I don't recall.
12 Q Do you remember anything else about
13 that meeting?
14 MR. LAND: Just object as lacking foundation
15 as to what meeting. Go ahead.
16 MS. SIEGEL: Well, I think we've established
17 that there was a meeting with the three persons,
18 Dr. Wiley, Dr. Kremer, Miss Marcial, shortly
19 after the back-to-back evaluations of Miss Fisher
20 and Miss Wimberly.
21 And I'm asking if he has any
22 recollection about her possible -- the possible
23 prognosis of Miss Marcial for success in the CRNA
24 program during that meeting.

Page 161

1 MR. LAND: And I'm objecting because you're
2 mischaracterizing what he said about timing of
3 the meeting. You just said shortly after. And I
4 don't think you've demonstrated or created
5 foundation that he knows when the meeting that
6 he's talking about happened. That's my
7 objection.
8 BY MS. SIEGEL:
9 Q Was there a meeting shortly after
10 those back-to-back evaluations?
11 A I believe there was.
12 Q Okay. And, in fact, you wrote a
13 summative shortly after that, didn't you?
14 A A summative what?
15 Q A summative evaluation for Miss
16 Marcial?
17 A I would have written one at the end of
18 the term.
19 Q Did you write one on the 1st of July,
20 2013?
21 A I don't recall.
22 Q Okay. Now, so some time between June
23 20th and the beginning of the next term it's
24 likely that you had this meeting with Miss

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 162

1 Marcial and Dr. Wimberly -- Dr. Wiley; is that
2 right?
3 A As I said, Dr. Wiley and I had a
4 series of meetings with Miss Marcial over the
5 summer term of 2013.
6 Q Okay. And when do you think the first
7 one was?
8 A I don't know.
9 Q In the course of any of those
10 meetings, did you give a prognosis as to what her
11 likelihood of success was?
12 A Likelihood of success of what?
13 Q In the CRNA program at Rush College of
14 Nursing?
15 A I don't recall.
16 Q I am handing you what has been
17 previously marked as Plaintiff's Exhibit 6.
18 Dr. Kremer, do you recognize Plaintiff's Exhibit
19 6?
20 A It appears to be a set of formative
21 evaluations, summative evaluation.
22 Q Is that your signature in the lower
23 right-hand corner?
24 A Yes, it is.

Page 164

1 August 20th of 2013?
2 A Yes.
3 Q And Miss Fisher has rated Miss Kam as
4 unsatisfactory on four different categories; is
5 that right?
6 A On four different items, yes.
7 Q And she makes an additional comment
8 that Miss Kam is an unsafe practitioner, right?
9 A Yes.
10 Q She makes the statement that Miss Kam
11 still does not comprehend basic principles of
12 anesthesia; do you see that?
13 A Yes.
14 Q And then there is some additional
15 comments in areas that she claims that she is
16 improving, right?
17 A Right.
18 Q And there are no outstanding ratings,
19 are there?
20 A No.
21 Q Then there's a second evaluation from
22 Miss Fisher dated August 15th of 2013; is that
23 right?
24 A That's right.

Page 163

1 Q Would you take a look and tell me if
2 this is a true and correct copy of the summative
3 evaluation that you prepared for the summer
4 semester of 2013 for a student named Karen Kam?
5 MR. LAND: Just note that the Bates numbers
6 on this exhibit are not sequential. It's missing
7 gaps.
8 THE WITNESS: Spring is crossed out, summer
9 is written in and it's dated in December. So I'm
10 not exactly sure when this was generated.
11 BY MS. SIEGEL:
12 Q That's fair. Would you look those
13 over and tell me if these appear to be true and
14 correct copies of evaluations that Karen Kam
15 received in the CRNA program at Rush?
16 A They appear to be. I don't know if
17 they're all the evaluations that were submitted
18 for that term. And looks like there is a --
19 there is a 2012 evaluation mixed in and her
20 evaluations from both the spring and summer term
21 of 2013.
22 Q All right. And if you look at the
23 second page of this exhibit, this appears to be
24 an evaluation by Eva Fisher of Karen Kam dated

Page 165

1 Q And here, again, there are four
2 different unsatisfactory ratings that she
3 receives?
4 A Yes.
5 Q And there are various satisfactory
6 ratings and five outstanding ratings, right?
7 A Right.
8 Q And on the third line on the
9 additional comments she makes the statement that
10 it's extremely unsafe for you to be in the OR
11 without knowledge of volatile agents; do you see
12 that?
13 A Yes.
14 Q If you look at the next page there is
15 a May 16th of 2013 evaluation of Miss Kam by Jill
16 Wimberly?
17 A Uh-huh.
18 Q Yes?
19 A Yes.
20 Q And she has given Miss Kam ten
21 unsatisfactory evaluations, right?
22 A Right.
23 Q And she makes the statement that -- if
24 you look on the second page of that evaluation

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 166

1 there is some handwritten notes. And in the
2 second full paragraph she makes the statement --
3 Miss Wimberly makes the statement, I'll read it
4 into the record, "The other instance that was
5 overly concerning" overly underlined twice,
6 "Concerning this day was that during Karen Kam's
7 second case (TKA/AS44 BMI 55) Karen was",
8 underlined, "Completely oblivious", underlined,
9 "To frequent", underlined, "Oversaturations",
10 underlined. Do you see that?
11 A The word is desaturations.
12 Q Okay. Thank you. And she continues,
13 quote, "I have experienced this utter unawareness
14 to things going on with or going on to her
15 patient on other instances I've worked with her",
16 end quote. Do you see that?
17 A Yes.
18 Q And did you talk with Miss Wimberly
19 about that?
20 A Probably.
21 Q Did you talk with Miss Kam about that?
22 A Very likely.
23 Q And did Miss Kam agree with the
24 evaluation?

Page 168

1 this is all the formative and summative
2 evaluations that were completed on Miss Kam
3 during her time in the program.
4 (Discussion outside the
5 record.)
6 BY MS. SIEGEL:
7 Q Looking over the Plaintiff's Exhibit
8 14 and looking at the ratings from Miss Fisher
9 and Miss Wimberly by comparison with other
10 evaluators over the term for work in clinicals,
11 would you say that the evaluations of Miss Fisher
12 and Miss Wimberly are consistent with the
13 evaluators -- with the ratings of other
14 evaluators of Miss Kam's performance?
15 A I haven't had the opportunity to
16 review every document in this file. And as I
17 said, I don't know if this comprises her entire
18 file of evaluations.
19 Q Well, of course, Miss Marcial did not
20 generate the evaluations and we're working with
21 what was produced to us. Do you see looking over
22 -- and I realize this is a voluminous document;
23 but are there things in here that appear to be
24 missing?

Page 167

1 A I don't recall.
2 Q Did she complain about her work with
3 Miss Wimberly?
4 A I don't recall.
5 Q And how did Miss Kam do in the program
6 ultimately?
7 A She graduated and she passed the
8 certification exam.
9 Q And as she progressed through the
10 program, how was her work typically evaluated by
11 other CRNAs apart from Miss Fisher and Miss
12 Wimberly?
13 A I would have to see the entire file to
14 be able to answer that question.
15 MS. SIEGEL: Could you mark this as the next
16 exhibit, please.
17 (Whereupon said document was
18 marked as Plaintiff's Exhibit
19 Number 14, for identification,
20 dated 3/16/18.)
21 BY MS. SIEGEL:
22 Q Have you had a chance to review that
23 exhibit?
24 A Briefly. I have no way of knowing if

Page 169

1 A I have no way of knowing that.
2 Q All right. And as she proceeded
3 through the program, is it not correct that Miss
4 Kam was increasingly recognized as having
5 outstanding clinical performance?
6 A I don't think that's an accurate
7 statement.
8 Q All right. And how would you
9 interpret her overall progress?
10 A I remember she had difficulty during
11 her pediatric rotation. One of the attending
12 anesthesiologist, Dr. Edmund Mangahas, has a
13 negative evaluation on one of the days he worked
14 with her.
15 Q Now, you've testified earlier that
16 Miss Wimberly was a pediatric cardiology CRNA?
17 A I don't think I testified anything to
18 that effect.
19 Q Okay. What was Miss Wimberly's forte?
20 A In what regard?
21 Q As a CRNA, as a clinician and as an
22 instructor?
23 A According to her clinical instructor
24 evaluations she's very bright and capable

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 170

1 clinically. She had an extensive pediatric
2 critical care background before she came into
3 anesthesia.
4 Q And what is Miss Fisher's background?
5 A I don't know.
6 Q Do you know what Miss Kam's
7 performance was in her didactics?
8 A I don't have that information in front
9 of me.
10 Q Does a 4.0 sound, right?
11 A She successfully completed the
12 didactic curriculum.
13 Q Now, if you look at the period of May
14 through August in 2013 where Miss Fisher gave her
15 2 unsatisfactory evaluations and Miss Wimberly
16 gave her an unsatisfactory evaluation both with
17 scathing criticisms that she was unsafe; would it
18 have been fair to her to tell her that at that
19 point she had three strikes against her?
20 MR. LAND: Can you read that question back,
21 please.
22 (Record read by the reporter.)
23 THE WITNESS: The May evaluation would have
24 reflected the spring term. So these grades

Page 171

1 didn't all occur in the same academic term.
2 BY MS. SIEGEL:
3 Q And she had -- in the second term she
4 had two unsatisfactories; is that right?
5 A Right.
6 Q And would it have been fair to her to
7 state that she had two strikes against her?
8 A We likely discussed that she had two
9 unsatisfactory evaluations and that was a source
10 of concern that if she progressed through the
11 term, she couldn't get any other unsatisfactory
12 evaluations so it became a moot point.
13 Q In the summer of 2013 did you counsel
14 Miss Kam to consider other alternatives to the
15 CRNA program?
16 A I don't recall.
17 Q Did you question how she fit into the
18 practice of anesthesiology?
19 A No, I didn't.
20 Q Would you pull out again Plaintiff's
21 Exhibit 10. It should be among your documents.
22 It's Miss Wimberly's January 20th, 2014,
23 evaluation of Miss Marcial.
24 MR. LAND: What one are you looking for?

Page 172

1 MS. SIEGEL: January 20th of 2014.
2 THE WITNESS: Oh, January 20th of 2014.
3 MS. SIEGEL: Right.
4 MR. LAND: I don't know. Elaine, we don't
5 have that.
6 MS. SIEGEL: No?
7 MR. LAND: Neither one of us do.
8 MS. SIEGEL: Off the record.
9 (Whereupon a recess was taken
10 at 3:36 p.m. and the
11 deposition continued at 3:45
12 p.m.)
13 BY MS. SIEGEL:
14 Q Okay. Here is Plaintiff's Exhibit 10
15 previously marked. Dr. Kremer, are you familiar
16 with Plaintiff's Exhibit 10?
17 A I've seen it, yes.
18 Q And, again, Miss Wimberly was assigned
19 to work with Miss Marcial. How long had she been
20 back in the program -- Miss Marcial been back in
21 the program before she was assigned to be working
22 with Miss Wimberly again?
23 A I think this would have been roughly
24 the third week.

Page 173

1 Q And is it your testimony that you were
2 unaware that Miss Marcial had been assigned to
3 work with Miss Wimberly again?
4 A I was.
5 Q When did you first become aware of the
6 assignment?
7 MR. LAND: Object as asked and answered this
8 morning.
9 BY MS. SIEGEL:
10 Q Do you recall?
11 A Only when I saw the evaluation.
12 Q Did you have occasion to talk with Mr.
13 Narbone about Miss Marcial's assignment to Miss
14 Wimberly?
15 A I don't know for sure. The only other
16 conversation I remember with him about that was
17 in the summer of 2013 and asked him to minimize
18 the interaction, but that was at that time. It
19 wasn't something that feasibly could have been
20 implemented for the duration of her time in the
21 program.
22 Q Why not?
23 A Because there were over 40
24 anesthetizing locations at Rush. Around 150

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 174

1 procedures were completed there every day.
2 Providers are moved around with some frequency.
3 So it is difficult to insure exactly who will be
4 assigned with whom at a given time.
5 Q Now, what was the point that you
6 requested that Miss Wimberly's contact with SRNAs
7 be minimized altogether?
8 MR. LAND: I'm sorry, could your read that
9 back?
10 (Record read by the reporter.)
11 BY MS. SIEGEL:
12 Q When?
13 A I don't recall.
14 Q Do you recall why?
15 A No.
16 Q Had you already put that request in by
17 January 20th of 2014?
18 A I don't know.
19 Q And did you have a meeting with Miss
20 Wimberly about this evaluation?
21 A We may have discussed it.
22 Q If you'll take a look at the second
23 page, look at the comments. Does that refresh
24 your recollection as to whether you may have

Page 176

1 Q Did she say it was because she wanted
2 -- Strike that.
3 Do you have any recollection of her
4 discussing working offsite so that she would be
5 in a supportive environment?
6 A I don't specifically recall such a
7 conversation.
8 Q Did she make a reference at any time
9 to wanting to go offsite so that her evaluations
10 would be free from bias?
11 A I recall that she was requesting to
12 have the opportunity to go to another clinical
13 site.
14 Q Did she give a reason?
15 A She may have.
16 Q But you don't recall?
17 A I don't recall.
18 Q As you sit here today is there a
19 reason that she couldn't have gone?
20 A I didn't hear the question.
21 Q As you sit here today is there a
22 reason why she couldn't do some training offsite
23 to be certain that she wasn't being evaluated in
24 a -- in a way that was free from bias?

Page 175

1 discussed this with Miss Wimberly?
2 A It's likely that we would have
3 discussed it. I don't know exactly where or when
4 that would have taken place.
5 Q And, again, do you have any
6 recollection of the content of the discussion?
7 A No, I don't.
8 Q If you'll direct your attention to
9 February 3rd of 2014. Did you meet with Miss
10 Marcial at that time to review her formative
11 evaluations?
12 A I may have.
13 Q And did you remind her at that point
14 that the instructors completing the formative
15 evaluations were credentialed faculty?
16 A I may have.
17 Q Did Miss Marcial request to work at an
18 offsite location?
19 A She did.
20 Q When did that occur?
21 A I don't recall exactly.
22 Q Why did she say she wanted to go
23 offsite?
24 A I don't recall.

Page 177

1 A That assumes that she was evaluated
2 with bias.
3 Q I'm not assuming that. I'm saying
4 that that may be the case, but what I'm asking
5 you is whether there were discussion of sending
6 her offsite to assure that she was in a situation
7 free from bias?
8 MR. LAND: Object to that question as vague.
9 THE WITNESS: I don't have a context for
10 bias or the assumption that any -- that there --
11 I don't have a context for bias.
12 BY MS. SIEGEL:
13 Q Well, what was Miss Marcial saying as
14 she objected to her evaluations?
15 A Regardless of the source as she
16 accrued more unsatisfactory evaluations from a
17 cross-section of clinical instructors, she always
18 refuted the accuracy and unfairness of those
19 evaluations.
20 Q And didn't it seem to be the case that
21 were she in an altogether different site, that
22 those objections would be answered?
23 A I'm not following the question.
24 Q All right. Didn't it seem that if

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 178

1 Miss Marcial were to do some of her training
2 offsite, that the kind of inaccuracies that she
3 claimed were infecting her evaluations at Rush
4 would not be an issue?
5 MR. LAND: Object as lacking foundation and
6 calling for speculation.
7 THE WITNESS: There would be no way of
8 knowing if her performance would be the same or
9 different at another clinical site.
10 BY MS. SIEGEL:
11 Q No, not unless she went there; isn't
12 that right?
13 A Yes.
14 Q Would you agree with me that sending
15 her to another site would be a means of testing
16 the validity of the Rush evaluations?
17 A No.
18 Q Why not?
19 A Because we had credentialed experts
20 evaluating Miss Marcial at Rush. And because I
21 contacted the only other site that we had
22 available that wasn't a specialty rotation site,
23 Skokie Hospital. I had two conversations with
24 Dr. Sam Parnass, the Chair of the Anesthesia

Page 179

1 Department, and Laurie Goldman who was our CRNA
2 clinical coordinator. And without going into
3 detail I asked if there was a chance they would
4 consider taking a student who was still on
5 one-to-one supervision. And they said they
6 didn't have the staff to support that.
7 Q When did you have that discussion?
8 A I don't recall. It was some time
9 after she made the request.
10 Q Did it come to your attention that on
11 April 8th of 2014 Miss Marcial submitted a
12 complaint to Shannon Shumpert alleging abuse and
13 mistreatment?
14 A On April 8th of 2014?
15 Q Yes.
16 A I know there was an anonymous
17 complaint submitted through the compliance
18 hotline, but I don't know -- I can't say for sure
19 that I know about a complaint that went to the
20 Title 9 Officer on that date.
21 Q What is the procedure for Title 9
22 complaints at Rush?
23 A Miss Shumpert is the Title 9 Officer.
24 And in conjunction with the Office of Legal

Page 180

1 Affairs and the Human Resources Department an
2 investigation is conducted surrounding Title 9
3 complaints.
4 Q What does that investigation -- What
5 would such an investigation consist of?
6 MR. LAND: Can I just ask why we are asking
7 about Title 9 investigation when this is not a
8 gender discrimination case?
9 MS. SIEGEL: Because the witness was talking
10 about Title 9 complaints.
11 MR. LAND: No, he mentioned what Shannon
12 Shumpert's role is which includes Title 9 work,
13 but that doesn't mean that he's talking about
14 Title 9 complaints.
15 BY MS. SIEGEL:
16 Q Did it come to your attention that
17 Miss Shumpert on or about April 8th of 2014
18 received a complaint of abuse and mistreatment
19 from Miss Marcial?
20 MR. LAND: I object as asked and answered.
21 You asked him that exact same question before and
22 we talked about it like two or three times.
23
24 BY MS. SIEGEL:

Page 181

1 Q You may answer.
2 A I don't recall a complaint at that
3 point in time.
4 Q Do you recall any other complaint from
5 Miss Marcial alleging abuse and harassment?
6 A Well, I was made aware of an anonymous
7 complaint to the compliance hotline alleging
8 differential treatment of current and former
9 students in the nurse anesthesia program, but I
10 think that was the summer of '14.
11 Q And did no one make you aware that
12 Miss Marcial had filed a complaint with the
13 compliance office at Rush?
14 A At what time?
15 Q In April of 2014.
16 A Not that I recall.
17 Q Were you aware in April of 2014 of a
18 legal claim brought by Miss Marcial?
19 A I think that was around the time she
20 retained her first attorney.
21 Q All right. And what was your
22 understanding of the legal issues that were
23 pending in April of 2014?
24 MR. LAND: Object to the question as vague.

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 182

1 MS. SIEGEL: You may answer.
 2 MR. LAND: Legal issues is really broad.
 3 THE WITNESS: Generally I recall that the
 4 concerns related to differential -- perceived
 5 differential treatment on the base of age,
 6 ethnicity and national origin.
 7 BY MS. SIEGEL:
 8 Q And how did you -- how did you become
 9 aware of those claims?
 10 MR. LAND: Objection to the extent it calls
 11 for communication with counsel. If you can
 12 answer that without talking about communications
 13 with counsel, go ahead.
 14 THE WITNESS: I can't.
 15 BY MS. SIEGEL:
 16 Q Did you receive any correspondence
 17 regarding Miss Marcial's claims?
 18 MR. LAND: Same objection. Instruct you not
 19 to answer.
 20 BY MS. SIEGEL:
 21 Q With the exception of correspondence
 22 from your counsel, did you get any correspondence
 23 regarding those claims?
 24 A It was through the Office of Legal

Page 184

1 ask him about did you see a document that legal
 2 counsel for Rush shared with him, I'm not going
 3 to let you ask him that.
 4 BY MS. SIEGEL:
 5 Q Did you see a document from Miss
 6 Marcial or her counsel regarding her claims?
 7 A Yes.
 8 Q And what was that?
 9 A It was correspondence from Sherry Bell
 10 Rothenberg to David Rice.
 11 Q What did it say?
 12 A I don't recall other than what I've
 13 already said.
 14 Q Did you tell Miss Marcial that she
 15 couldn't resume her work in the program because
 16 of her legal claim of discrimination?
 17 A I did not.
 18 Q Did you write to her, "Thank you for
 19 your voicemail regarding the medical clearance
 20 you received. Since discussions are ongoing
 21 between our attorney and your lawyers, do not
 22 return to the OR until there is resolution on the
 23 legal front"?
 24 A That is correct. And the return of

Page 183

1 Affairs.
 2 Q Did they transmit to you anything from
 3 Miss Marcial's counsel?
 4 MR. LAND: You know, he's not going to talk
 5 about what legal counsel shared with him. That's
 6 what you just asked, what did they transfer
 7 anything to him. We're not talking about what
 8 they decided to give him.
 9 MS. SIEGEL: But if it's not a communication
 10 from university counsel, it's not covered by the
 11 privilege nor is it work product.
 12 MR. LAND: But that's what you just asked.
 13 Did they, meaning the Office of Legal Counsel,
 14 share with him certain documents and I am not
 15 going to let him answer questions about what
 16 legal counsel decided to share with him or not.
 17 MS. SIEGEL: The documents I asked about
 18 were specifically documents from Miss Marcial,
 19 and his notice of those claims is relevant and
 20 it's not sheltered from the attorney/client -- by
 21 the attorney/client privilege or the work product
 22 doctrine.
 23 MR. LAND: If you want to ask him about did
 24 he see a document, you can. But if you want to

Page 185

1 Miss Marcial to the clinical area was negotiated
 2 by counsel for Rush and her counsel.
 3 Q And approximately when did she return?
 4 A I couldn't say for sure.
 5 Q On the 22nd of April did -- was Miss
 6 Marcial offered a 5-week training period to begin
 7 on May 5th?
 8 A That sounds correct.
 9 Q And what was -- Did you take any
 10 measures -- Strike that.
 11 Did you take any measures to assure
 12 that when she returned that Miss Marcial would be
 13 evaluated fairly and accurately?
 14 A As we discussed earlier, fair can't be
 15 quantified.
 16 Q So did you take any steps to assure
 17 fairness?
 18 A Miss Marcial was assigned with a
 19 cross-section of clinical instructors at the
 20 medical center. And with the resources we had
 21 available, that was -- that was the best
 22 available option.
 23 Q And how were those -- how was that
 24 cross-section chosen?

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 186

Page 187

1 A Mr. Narbone made the daily clinical
2 assignments.

3 Q Did you take any role to review her
4 evaluations to ascertain whether or not they were
5 fair?

6 MR. LAND: At what time?

7 THE WITNESS: There is no way to quantify
8 fairness of evaluations.

9 MS. SIEGEL: I'm sorry, could I have the
10 answer back, please.

11 (Record read by the reporter.)

12 MR. LAND: I was trying to ask if you were
13 talking about that time period in May because
14 you've already gone over other evaluations and
15 asked him questions about that. I wasn't sure if
16 you were talking about prior questions or this
17 time period.

18 BY MS. SIEGEL:

19 Q Does that answer apply to the
20 evaluations that were performed In May after
21 Ms. Marcial began the five-week training program?

22 A What's the question?

23 MS. SIEGEL: Can we have the question again,
24 please.

1 (Record read by the reporter as
2 follows:

3 "Q Does that answer apply to
4 the evaluations that were
5 performed In May after
6 Ms. Marcial began the
7 five-week training program?")

8 THE WITNESS: My answer is it is not
9 possible to quantify fairness of a formative
10 clinical evaluation.

11 BY MS. SIEGEL:

12 Q And you were speaking with reference
13 to the 5-week period in May in which Miss Marcial
14 had been given an opportunity to continue her
15 training; is that right, May of 2014?

16 A I am not following.

17 Q You stated that it's not possible to
18 quantify fairness in formative evaluations; is
19 that correct?

20 A Yes.

21 Q That's your testimony?

22 A It is.

23 Q Okay. And does that testimony apply
24 to the 5-week period in May and June of 2014 when

Page 188

Page 189

1 Miss Marcial was continuing her training?

2 A It is a general observation related to
3 testing and measurement.

4 Q Are there ways of -- in testing and
5 measurement of investigating for validity?

6 A Sure.

7 Q And how do you do that?

8 A Psychometric tests can be performed to
9 determine if a measure -- measures what it is
10 intended to measure.

11 Q And reliability is another factor;
12 isn't that right?

13 A Those pertaining -- those terms
14 pertain to quantitative items like test questions
15 and reliability refers to the replicability of an
16 item to consistently capture the same kinds of
17 information.

18 Q Now, can you judge qualitatively the
19 fairness and validity of formative evaluations
20 with respect to bias?

21 A No.

22 Q And is it fair to say that you took no
23 steps to investigate whether the evaluations of
24 Miss Marcial during that five-week training

1 period were flawed by rater bias?

2 A I had no reason to believe that the
3 evaluations were flawed by rater bias.

4 Q And you didn't investigate to
5 determine whether or not there were rate bias?

6 A There was no reason to believe that
7 there was rater bias.

8 Q Did you investigate in any way to
9 determine whether or not there were rater bias?

10 A There was no reason to believe that
11 there was rater bias.

12 MR. LAND: Can we take a short break?

13 MS. SIEGEL: Sure.

14 (Whereupon a recess was taken
15 at 4:12 p.m. and the
16 deposition resumed at 4:22
17 p.m.)

18 MS. SIEGEL: In an off-the-record discussion
19 we agreed to adjourn for the day. We will have a
20 subsequent session to review certain documents
21 that are in the process of assembly and not yet
22 been produced by the defendants. And we will
23 have approximately an additional hour of
24 questioning of the witness at the same time.

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 190

1 MR. LAND: And the only thing I would add is
2 that you kindly agreed to give us some list of
3 topics that you would be asking about for that
4 extra hour of time that you could have done today
5 so that we can narrow our preparation efforts
6 accordingly. We are mutually agreeing to that,
7 right?

8 MS. SIEGEL: Yes, that's correct.

9 MR. LAND: All right. We'll reserve
10 signature.

11 (Whereupon the deposition
12 concluded at 4:21 p.m.)
13
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Page 191

1 IN THE UNITED STATES DISTRICT COURT
2 NORTHERN DISTRICT OF ILLINOIS
3 EASTERN DIVISION
4 MARICEL MARCIAL,)
5 Plaintiff,)
6 vs.) No. 16 CV 06109
7 RUSH UNIVERSITY MEDICAL CENTER;)
8 DR. MICHAEL KREMER, in his)
9 individual capacity; RAY)
10 NARBONE, in his individual)
11 capacity; and JILL WIMBERLY, in)
12 her individual capacity;)
13 Defendants.)
14
15

16 I, MICHAEL J. KREMER, Ph.D., CRNA,
17 CHSE, FNAP, FAAN, state that I have read the
18 foregoing transcript of the testimony given by me
19 at my deposition on March 16, 2018, and that said
20 transcript constitutes a true and correct record of
21 the testimony given by me at said deposition except
22

23 (CONTINUED ONTO NEXT PAGE FOR JURAT.)
24

Page 192

1 As I have so indicated on the errata sheets
2 provided herein.
3
4
5

6 MICHAEL J. KREMER, Ph.D., CRNA, CHSE, FNAP, FAAN
7
8
9

10 No corrections (Please initial) _____
11 Number of errata sheets submitted _____ (pgs)
12
13
14

15 SUBSCRIBED AND SWORN TO
16 before me this day of
17 , A.D., 2018.
18
19

20 Notary Public
21
22
23
24

Page 193

1 STATE OF ILLINOIS)
2) SS.
3 COUNTY OF LAKE)
4

5 I, JULIE WALSH, CSR, and notary public
6 in and for the County of Lake and State of
7 Illinois, do hereby certify that previous to the
8 commencement of the examination, said witness was
9 duly sworn by me to testify the truth; that the
10 said deposition was taken at the time and place
11 aforesaid; that the testimony given by said witness
12 was reduced to writing by means of shorthand and
13 thereafter transcribed into typewritten form; and
14 that the foregoing is a true, correct, and complete
15 transcript of my shorthand notes so taken as
16 aforesaid.

17 I further certify that there were
18 present at the taking of the said deposition the
19 persons and parties as indicated on the appearance
20 page made a part of this deposition.

21 I further certify that I am not counsel
22 for nor in any way related to any of the parties to
23 this suit, nor am I in any way interested in the
24 outcome thereof.

Maricel Marcial v.

Deposition of Michael Kremer
March 14, 2018

Page 194

1 I further certify that this certificate
2 applies to the original signed and certified
3 transcripts only. I assume no responsibility for
4 the accuracy of any reproduced copies not made
5 under my control or direction.

6 IN TESTIMONY WHEREOF I have hereunto set
7 my hand and affixed my notarial seal this 29th day
8 of March, 2018.

9

10

11

12

13

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15

16 My Commission Expires

17 August 5, 2020

18

19


20

21

22

23

24


Julie Walsh, CSR
Illinois CSR No. 084-004032

EXHIBIT

A20

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

MARICEL MARCIAL,)	
)	
Plaintiff,)	
)	Civil Action No.
vs.)	16-CV-06109
)	
RUSH UNIVERSITY MEDICAL)	
CENTER, et al.,)	
)	
Defendants.)	

The deposition of KAREN B. KREINER,
M.D., taken in the above-entitled cause before
Teresa Volpentesta, a notary public within and
for the County of Cook and State of Illinois,
taken pursuant to the Federal Rules of Civil
Procedure for the United States District Courts,
at Suite 2200, 120 South Riverside Plaza,
Chicago, Illinois, on the 12th day of March,
A.D. 2018, at 4:15 o'clock p.m.

<p style="text-align: right;">Page 2</p> <p>1 APPEARANCES:</p> <p>2</p> <p>3 ELAINE K.B. SIEGEL & ASSOC., P.C.</p> <p>4 (53 West Jackson Boulevard, Suite 405</p> <p>5 Chicago, Illinois 60604</p> <p>6 312.583.9970), by:</p> <p>7 Siegedlaw@aol.com</p> <p>8 MR. MARK GOLDRICH and</p> <p>9 MS. ELAINE K.B. SIEGEL,</p> <p>10 On behalf of the Plaintiff;</p> <p>11</p> <p>12 HUSCH BLACKWELL, LLP</p> <p>13 (120 South Riverside Plaza, Suite 2200</p> <p>14 Chicago, Illinois 60606</p> <p>15 312.655.1500), by:</p> <p>16 Karen.Courtheoux@huschblackwell.com</p> <p>17 MS. KAREN L. COURTHEUX,</p> <p>18 On behalf of the Defendants.</p> <p>19</p> <p>20 ALSO PRESENT:</p> <p>21 Ms. Maricel Marcial</p> <p>22</p> <p>23</p> <p>24</p>	<p style="text-align: right;">Page 4</p> <p>1 (Witness duly sworn.)</p> <p>2 KAREN B. KREINER, M.D.,</p> <p>3 called as a witness herein, having been first</p> <p>4 duly sworn, was examined and testified as</p> <p>5 follows:</p> <p>6 EXAMINATION</p> <p>7 BY MS. COURTHEUX:</p> <p>8 Q. Hello again, Dr. Kreiner.</p> <p>9 A. Hello.</p> <p>10 Q. Thanks again for being here today.</p> <p>11 Have you had your deposition taken before?</p> <p>12 A. Yes. Not on this case, but on other</p> <p>13 cases, yes.</p> <p>14 Q. How many times?</p> <p>15 A. I would say at least five.</p> <p>16 Q. Okay. We will review that in a few</p> <p>17 minutes. I just wanted to know, because we will</p> <p>18 go over some ground rules today, and I want to</p> <p>19 make sure you are familiar with them.</p> <p>20 The first ground rule for the</p> <p>21 deposition is to ask you to please wait for me</p> <p>22 to finish my question before you begin</p> <p>23 answering. Is that okay?</p> <p>24 A. That's fine.</p>
<p style="text-align: right;">Page 3</p> <p>1 INDEX</p> <p>2 WITNESS PAGE</p> <p>3 KAREN B. KREINER, M.D. 4</p> <p>4 BY MS. COURTHEUX 52</p> <p>5 BY MS. SIEGEL 60</p> <p>6 BY MS. COURTHEUX 62</p> <p>7 BY MS. SIEGEL</p> <p>8</p> <p>9</p> <p>10</p> <p>11 EXHIBITS</p> <p>12 NUMBER PAGE</p> <p>13</p> <p>14 No. 1 Handwritten Notes 13</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>	<p style="text-align: right;">Page 5</p> <p>1 Q. Please also answer audibly. No</p> <p>2 gestures, no sort of non-verbal responses, only</p> <p>3 verbal responses; is that okay?</p> <p>4 A. That's okay.</p> <p>5 Q. And that's because Teresa our court</p> <p>6 reporter will be taking down the things that you</p> <p>7 say, and she can't take down just a gesture, of</p> <p>8 course.</p> <p>9 We will ask you to give full and</p> <p>10 complete answers to our questions, and also, if</p> <p>11 you don't understand a question, please say so.</p> <p>12 After I ask it, if you answer it, I</p> <p>13 will assume that you understand what I meant.</p> <p>14 Is that okay?</p> <p>15 A. That is okay.</p> <p>16 Q. All right. Please let me know if you</p> <p>17 would like to take a break at any point. We can</p> <p>18 do that.</p> <p>19 A. I might need -- an emergency might</p> <p>20 come through around 5:00 or just after 5:00,</p> <p>21 which I will need to step out for.</p> <p>22 Q. Understood. The only thing that we</p> <p>23 will ask is for you to finish answering whatever</p> <p>24 question has just been asked before we take any</p>

Page 6	Page 8
<p>1 break.</p> <p>2 A. Okay.</p> <p>3 Q. But if you get a phone call, you</p> <p>4 know, as soon as you answer the question, please</p> <p>5 go ahead and take it. Understood?</p> <p>6 A. Okay.</p> <p>7 Q. Lastly, are you taking any</p> <p>8 medications, or do you have any other</p> <p>9 circumstances that will make it difficult for</p> <p>10 you to understand or respond to questions today?</p> <p>11 A. No.</p> <p>12 Q. Thank you very much.</p> <p>13 Well, to start with, would you please</p> <p>14 walk us through your education, starting with</p> <p>15 undergraduate?</p> <p>16 A. Okay. As on my CV, I trained as a</p> <p>17 medical doctor in Cape Town, South Africa. It</p> <p>18 is a seven-year program, six-year degree</p> <p>19 program, and then a year of compulsory</p> <p>20 internship.</p> <p>21 I then went to Cleveland where I did</p> <p>22 a year of internal medicine residency as -- I</p> <p>23 had to redo my internship.</p> <p>24 I then did two years as a pathology</p>	<p>1 to address their psychiatric needs, so it is</p> <p>2 basically looking at the interface between</p> <p>3 medicine -- general medicine and surgery and</p> <p>4 psychiatry.</p> <p>5 Q. And can you also explain what it</p> <p>6 means to be a qualified psychoanalyst?</p> <p>7 A. What it means is I did five years of</p> <p>8 courses in psychoanalysis in various fields.</p> <p>9 I had to undergo my own analysis and</p> <p>10 then also pass various tests and exams and write</p> <p>11 various papers and have a number of supervised</p> <p>12 patients in order to fulfill the requirements</p> <p>13 for that diploma.</p> <p>14 Q. Okay. Are you licensed to practice</p> <p>15 medicine in the State of Illinois?</p> <p>16 A. I am.</p> <p>17 Q. Any other states?</p> <p>18 A. No.</p> <p>19 Q. Are you board certified?</p> <p>20 A. Yes, I am, and I have been</p> <p>21 re-certified once.</p> <p>22 Q. Do you have any history of</p> <p>23 professional discipline; any reprimands,</p> <p>24 suspensions of your license, anything like that?</p>
Page 7	Page 9
<p>1 resident, and then I switched to psychiatry</p> <p>2 where I came to Rush and did -- they only</p> <p>3 required me to do three years because of my one</p> <p>4 year of internal medicine, and I did three years</p> <p>5 of general psychiatry residency, and then I</p> <p>6 stayed on an extra year to do a fellowship in</p> <p>7 consultation liaison psychiatry.</p> <p>8 So that's where my formal medical</p> <p>9 education ended. I have also -- I am a</p> <p>10 qualified psychoanalyst and I trained for five</p> <p>11 years at the Chicago Institute for</p> <p>12 Psychoanalysis.</p> <p>13 Q. Thank you. Just a couple of</p> <p>14 follow-ups to that.</p> <p>15 What is consultation liaison</p> <p>16 psychology?</p> <p>17 A. Psychiatry.</p> <p>18 Q. I am sorry. Psychiatry. Thank you.</p> <p>19 A. It is when psychiatrists get called</p> <p>20 in the general hospital to see all kinds of</p> <p>21 medical and surgical patients, whether they have</p> <p>22 psychiatric issues arising from their hospital</p> <p>23 stay, or whether it is to treat psychiatric</p> <p>24 patients who are on a medical or surgical floor</p>	<p>1 A. No.</p> <p>2 Q. Could you describe your medical</p> <p>3 practice? How many providers are in your</p> <p>4 practice?</p> <p>5 A. I am a solo practitioner.</p> <p>6 Q. Do you have any staff working with</p> <p>7 you?</p> <p>8 A. No.</p> <p>9 Q. Had you met or did you know</p> <p>10 Ms. Marcial in any capacity before she came in</p> <p>11 as a patient?</p> <p>12 A. No.</p> <p>13 Q. Okay. Let's circle back to the other</p> <p>14 depositions you mentioned. You said there were</p> <p>15 at least five.</p> <p>16 Is that about right? Was it about</p> <p>17 five or more than that, do you think?</p> <p>18 A. I don't think it was -- I don't think</p> <p>19 it is more than five.</p> <p>20 Q. And how many of those depositions</p> <p>21 were in your capacity as an expert?</p> <p>22 A. You mean as a psychiatrist giving</p> <p>23 psychiatric -- I am not sure I understand your</p> <p>24 question.</p>

<p style="text-align: right;">Page 10</p> <p>1 Q. Understood. So how many of those 2 depositions were you called as an expert 3 witness? 4 In other words, you weren't called in 5 your capacity as having been the treating 6 physician for a party, but rather to weigh in 7 generally with an expert opinion on the facts of 8 a particular case? 9 A. I believe one time I was called in as 10 an expert, and I don't know if it is five 11 exactly, but the other times were because I was 12 the treating physician and my patient was 13 involved in legal action, and as a result, 14 similar to this, there was a lawsuit and my 15 testimony was required. 16 Q. Okay. Understood. How recently was 17 your most recent testimony in a deposition? 18 A. It was within the last -- we are now 19 in March, so I believe it was in November. That 20 could be wrong. It was in the -- definitely 21 within the last six months. 22 Q. Okay. Dr. Kreiner, you are here for 23 your deposition pursuant to a subpoena; is that 24 right?</p>	<p style="text-align: right;">Page 12</p> <p>1 speculate. 2 So August 15, 2013 was my first 3 encounter with her. 4 Q. And if you would like to refer to 5 your notes, I think it will easier for all of us 6 if we use the version that we have page numbers 7 on actually. So I will -- 8 A. I just -- I am not sure. I have them 9 organized in the way that I know is the right 10 order. I am not sure if you have them in the 11 right order. 12 Q. I am not sure, either. They are just 13 exactly as you gave them to us, but you should 14 continue to refer to the ones you have. 15 In some of my questions, I will ask 16 you to turn to a particular page, so for that 17 reason, I would like to hand you this packet of 18 documents. Do you recognize what this is? 19 A. Yes, they are my notes. 20 MS. SIEGEL: Could we have a set of those, 21 please? 22 MS. COURTHEOUX: Yes. Here you go. This 23 is Exhibit 1, please. 24</p>
<p style="text-align: right;">Page 11</p> <p>1 A. That's correct. 2 Q. And you also provided documents to us 3 pursuant to a subpoena? 4 A. That's correct. 5 Q. Can you just explain how you 6 identified the documents to produce to us? 7 A. Well, you requested medical records 8 on Maricel, and I went to my file, and these 9 were the records that were there and those were 10 the ones that I provided. 11 Q. So you had a certain file where you 12 kept -- 13 A. This is the file that I brought with 14 me. 15 Q. Okay. Thank you. In the course of 16 your practice, you have had occasion to treat 17 Ms. Marcial? 18 A. Yes. 19 Q. When was her first visit? 20 A. I am going to refer to my notes as 21 this case has been a long time ago, and so I 22 want to make sure that I report everything 23 accurately, and so I am going to very much stick 24 to what is in my notes and not wander off and</p>	<p style="text-align: right;">Page 13</p> <p>1 (Whereupon Kreiner Deposition 2 Exhibit No. 1 was marked for 3 identification.) 4 BY MS. COURTHEOUX: 5 Q. So Maricel's first visit was on 6 August 15, 2013. 7 Do you know how it came to pass that 8 Maricel sought out your practice? 9 A. At that time, I was the psychiatrist 10 for the Rush University Counseling Center, and 11 so she had seen Dr. Terebessy, and so 12 Dr. Terebessy then would refer students/patients 13 to me who needed evaluations for medication. 14 Q. Had Dr. Terebessy told you anything 15 about Maricel prior to her first visit? 16 A. As I said before, this has been a 17 long time ago. I don't remember. 18 It was customary, however, that she 19 would call and leave a message about the 20 students, but I cannot say specifically in this 21 case that it happened, because I don't have 22 anything documented. 23 Q. When Dr. Terebessy called and left 24 messages about students generally, not referring</p>

<p style="text-align: right;">Page 14</p> <p>1 to Maricel now, what types of information did 2 she usually provide? 3 A. You know, I haven't worked with the 4 students for awhile now since I believe 2016, 5 and so I don't remember. 6 Q. Why did you stop working with the 7 students? 8 A. I worked with the students for a long 9 time, at least ten years, and sometimes enough 10 is enough. 11 Q. Was that your decision? 12 A. What's that? 13 Q. Was it your decision to stop? 14 A. Yes. 15 Q. Do you recall when Maricel first came 16 in whether you felt you knew anything about her 17 in advance? 18 A. As I said, I am going to stick to 19 what I have got written, because I would just be 20 speculating. 21 Q. I am just asking if you remember. 22 A. No. I mean, this is back in 2013. 23 Q. What usually happens at a patient's 24 first visit?</p>	<p style="text-align: right;">Page 16</p> <p>1 you could read that to me? 2 A. Nursing Anesthesia. 3 Q. That's her program? 4 A. Yes. 5 Q. Okay. Thank you. What did Maricel 6 tell you at her first visit? 7 A. Well, I am going to refer -- if we 8 could just walk through the notes, because -- so 9 if we go to Page 2. They are the same. 10 So firstly I go through the medical 11 history, and she reported that had a breast lump 12 and was having yearly mammograms. 13 I asked her what medication she was 14 on, and she wasn't taking -- she wasn't on the 15 pill. She wasn't taking any medications. 16 I asked her if she had any drug 17 allergies. She denied that. I asked her if she 18 smoked cigarettes. She said no. She drank 19 occasionally, and there was no use of any drugs. 20 And then I always ask about family 21 history. She said there was no depression, no 22 bipolar disorder, no schizophrenia, and then she 23 told me she had -- if I read my notes correctly, 24 an aunt with worries and was a question mark of</p>
<p style="text-align: right;">Page 15</p> <p>1 A. So what usually happens is I take -- 2 as you can see on the cover sheet, I would take 3 their name, their address, date of birth, an 4 emergency contact. 5 I would -- for the students, I would 6 always -- if there were more than one counselor, 7 I would see what counselor they were seeing, and 8 then I would also write what program they were 9 in, and she was in the Nursing Anesthesia 10 Program. 11 So that's how every visit would 12 start, and then it would become a general 13 psychiatric interview, and that's what follows 14 next. 15 Q. Okay. Let's look at the first page 16 of the packet that I have here, which seems to 17 match up with your first page. This is marked 18 Kreiner 1. 19 It looks like you have got Maricel 20 with her address, phone number, date of birth, 21 emergency contact, the name of Dr. Terebessy; is 22 that correct? 23 A. Yes. 24 Q. And then what's that last line, if</p>	<p style="text-align: right;">Page 17</p> <p>1 whether this was real clinical anxiety, and then 2 lastly, she said in her family history she had a 3 brother on drugs, and I have there in quotes 4 "jumped," and I am not sure -- I can't read the 5 next word if that's suicide or not. I am not 6 sure. I don't want to say it is, because I 7 can't read my writing. 8 Q. Okay. 9 A. Then I ask her about past psychiatric 10 history, and she said she had seen an acute care 11 doctor and had took one dose of Zoloft, and it 12 made her really anxious and it felt like her 13 skin was crawling out of her, and it was just 14 25-milligrams, and she had taken one dose. 15 Q. Is that a relatively low dose, or how 16 would you characterize the dose? 17 A. Yeah, that's a low dose, but 18 certainly people can have a very anxious 19 response to just a very low dose of Zoloft. 20 That can be seen. 21 Q. Next to the word Zoloft in your 22 notes, can you read what's to the right of that? 23 A. Very anxious. 24 Q. Okay. Can we proceed to the next</p>

Page 18

1 page? That's Page 3.

2 A. Okay. So now moving to what was
3 presently going on. She was about to be on a
4 leave of absence. She reported had a man in
5 with Crohn's and had got written up, also had
6 two bad evals, and I can't read the word after
7 that.

8 The next line says tied to work
9 performance, anxiety -- the next line says
10 anxiety increased and -- there is something
11 about a lapse of memory. If it is simple
12 things, lapse of memory, I can't read it.

13 She would wake up at night -- she
14 would wake up terrified; are they are going to
15 expel me.

16 Her anxiety was high, high. Those
17 are what the arrows mean, but then her anxiety
18 had been high, high, and then it had gone down.

19 She was sleeping four to five hours a
20 night, and that had improved since. She was up
21 to seven hours a night.

22 She used to have to force herself to
23 eat. It was very -- I put a plus meaning that
24 was really hard -- she really had to force

Page 19

1 herself to eat, but now her appetite had been
2 about back to normal. She couldn't keep
3 anything down before.

4 I think the next line reads with her
5 loss of appetite, she was anxious about stuff
6 coming back. She also felt embarrassed about
7 it, worried about if and when going to graduate,
8 and in brackets also have loans. I presume
9 that's student loans.

10 Her focus was okay, could retain
11 some. Once in awhile felt sad and crying. She
12 had been running and doing yoga to decrease the
13 tension.

14 Her energy level was fair. Some days
15 had to push self; other days, can get into it.
16 Something holding me from being myself. Because
17 of what's going on, embarrassed, humiliated,
18 what is going on.

19 No suicidal ideation, more irritable
20 than usual. In the past, no episodes of
21 depression, but had anxiety in school before
22 when didn't feel -- I can't read those two
23 words. I am sorry.

24 Q. That's okay.

Page 20

1 A. Then I did a screening. There was no
2 history of anorexia, bulimia, no history of
3 mania or hypermania, no history of seizures or
4 headaches.

5 Her thyroid had been checked, no
6 history of obsessive/compulsive disorder, and I
7 assessed her as having an adjustment disorder
8 with anxiety that was getting better.

9 The patient wanted to be on
10 medication. I wasn't sure if medication was
11 indicated, but I said we could try Celexa
12 10-milligrams, and I explained the risks and
13 benefits of taking the medicine.

14 Q. Thank you for walking us through
15 that.

16 If you could turn back to Page 3, I
17 just have some questions about what you shared
18 with us.

19 A. Sure.

20 Q. So there were a couple of points when
21 it seemed like there were comparisons between
22 two points in time.

23 For example, anxiety increased and
24 then anxiety was very high?

Page 21

1 A. Right.

2 Q. Do you have a sense of when those
3 points in time were?

4 A. I can't say exactly when and exactly
5 the days or months when they were. All I can
6 tell you is that before she came to see me, it
7 appears from my notes that she was very, very
8 anxious and was not sleeping well. Her appetite
9 had been very, very poor, and but it had
10 improved some by the time she had got to see me.

11 Q. Why had it improved before she got to
12 you? Specifically, I am referring to the
13 sleeping and eating.

14 A. I don't know. Sometimes -- I don't
15 know. I didn't write -- I didn't ask. I don't
16 know. Sometimes it can just improve. I don't
17 know.

18 Q. And you are not sure how far -- how
19 recently it had improved before she came to see
20 you?

21 A. No.

22 Q. Under the discussion of appetite, you
23 said that Maricel was anxious about something
24 coming back?

6 (Pages 18 to 21)

<p style="text-align: right;">Page 22</p> <p>1 A. She was anxious about -- all I is 2 have is with loss of appetite, she was anxious 3 about coming back. I am not sure. This is 4 2013. I am not sure. 5 Q. Could it have meant coming back after 6 a leave of absence in the program? 7 MS. SIEGEL: Calls for speculation. 8 THE WITNESS: I would be speculating if I 9 said yes. 10 BY MS. COURTHEOUX: 11 Q. That's one of the things it could 12 mean, I take it? 13 A. It could, or it could also mean she 14 was anxious about her anxiety coming back and 15 getting bad again. 16 Q. A couple lines down from there you 17 mention that Maricel expressed feeling 18 embarrassed about it. What did you understand 19 "it" to mean? 20 A. Again, this is 2013. I don't 21 remember. 22 Q. Further down, she mentions again 23 embarrassment, humiliation with what is going 24 on.</p>	<p style="text-align: right;">Page 24</p> <p>1 Q. As a psychiatrist, when you hear a 2 patient say there is something holding me back 3 from being myself, how do you interpret that? 4 A. I mean, it can be -- well, here the 5 answer is in the next line. I wrote the answer. 6 Q. Okay. 7 A. Something holding me back from being 8 myself, in brackets, because of what's going on; 9 embarrassed, humiliated with what's going on. 10 Q. Okay. I missed "because of." I 11 didn't understand that. 12 Now, toward the bottom you mention 13 that Maricel told you she had had anxiety in 14 school before? 15 A. Yes. 16 Q. Do you know if she meant previously 17 within her program or previously like in another 18 stage of schooling? 19 A. I don't know the answer to that. 20 Q. And you don't know in terms of time 21 how long ago that would have been? 22 A. No. 23 Q. What is an adjustment disorder with 24 anxiety?</p>
<p style="text-align: right;">Page 23</p> <p>1 A. Again, I would say there it is either 2 what was going on at school or embarrassed 3 that -- about her anxiety. 4 A lot of patients get embarrassed and 5 humiliated, they need to come and see a 6 psychiatrist. So it could be either, and I 7 would be speculating to say which one it was. 8 Q. At this first visit, did you talk 9 much about school with Maricel? 10 A. Well, I could only comment on what I 11 have documented. 12 Q. I understand. I am trying to 13 understand, though, you know your habit of 14 note-taking, so would you say that if school is 15 reflected only at certain points in the 16 conversation, those were the only times it was 17 raised? 18 A. I mean, this is an hour appointment, 19 so if I wrote down everything that the person 20 said, you would have, you know, reams and reams 21 of paper so I try and write down the main points 22 as well as the main clinical symptoms, because I 23 am doing a medicine evaluation. I am not her 24 treating therapist.</p>	<p style="text-align: right;">Page 25</p> <p>1 A. So it is when there is a situation 2 that is causing anxiety, and that's why -- and 3 you have some kind of stressor giving you 4 anxiety, and so we label that an adjustment 5 disorder with anxiety, and -- yeah. 6 Q. How would you characterize what you 7 believed Maricel's stressor to be at the time? 8 A. At the time, she was about to be 9 going on a leave of absence, and I -- from 10 school, and I have seen many Rush students, and 11 that's always a very stressful thing for them. 12 Q. The leave itself? 13 A. Well, just the whole process of being 14 put on leave and taking leave is very stressful, 15 what has led up to taking the leave. 16 Q. And in Maricel's case, what led up to 17 taking the leave? 18 A. Well, again, I want to stick to what 19 I have written, because I don't want anything to 20 be inaccurate so... 21 Q. Well, in that case, I think I am 22 asking you to interpret your notes for us. 23 A. It would be total speculation the 24 exact reason why she took leave. I don't know.</p>

Page 26

1 Q. Based on your notes, would you say
2 that issues in her work performance could be the
3 stressor or one of the stressors?

4 I see that here on the fourth line of
5 Page 3.

6 A. Oh, yeah, she reported that she had
7 two bad evals and had got written up. I am not
8 going to speculate whether that was the reason
9 why she took a leave. I don't know. I don't
10 remember.

11 Q. Is it your impression that some of
12 the conditions that are described here at the
13 top of Page 3 were contributing to her stress at
14 the time?

15 A. Absolutely.

16 Q. And specifically, that would include
17 the bad evaluations, getting written up, work
18 performance, lapse of memory; is that fair?

19 A. Well, up until you said lapse of
20 memory, that would be fair, because the lapse of
21 memory, whether that was a stressor or whether
22 that was secondary to her anxiety is not clear.

23 Q. I see. So just what comes above that
24 in the notes?

Page 28

1 on 9/6 of '13, and she had been on 10-milligrams
2 of Celexa for about 18, 19 days.

3 She said her side effects, she had a
4 twitch in her right eye. It was not visible
5 to -- but she could feel it.

6 She also had a queasiness in the
7 morning, in the a.m., but she was able to eat
8 and her appetite was okay.

9 She said also the queasiness was not
10 bothersome, but she felt it most of the time,
11 and after she ate food, she felt okay.

12 To the left, the current stress was
13 of being held back and not being able to be in
14 school, and then moving on, held back for
15 school, which is I think the word I wrote is
16 depressing.

17 A lot of pretty -- a lot of pretty
18 good days, more optimistic. Unfortunately, I
19 can't read but, but there were question mark
20 whether there was any changes from the
21 medication yet.

22 She was not -- she was not --
23 something in tears, so it doesn't seem like she
24 was crying anymore. She was sleeping eight

Page 27

1 A. Yes.

2 Q. I see. Turning back to Page 4, could
3 you say again the name of the drug that you
4 prescribed at the end of that first meeting?

5 A. Celexa.

6 Q. And what did you explain were the
7 benefits and risks of Celexa?

8 A. Well, Celexa is a very typical
9 selective serotonin reuptake inhibitor. It is
10 commonly used to treat anxiety or depression.

11 It is a very low risk, high benefit
12 drug. It is very good for treating young women,
13 because it doesn't give you any weight gain.

14 The negatives are it can sometimes
15 increase anxiety, occasionally increase
16 depression, occasionally cause suicidal
17 thoughts, can give you stomach upset, give you
18 sleep problems, and sexual dysfunction.

19 Q. Anything else?

20 A. And if you have a bipolar
21 predisposition can make you manic.

22 Q. Can we turn to the next appointment
23 and walk through your notes there?

24 A. Yes. So the next time I saw her was

Page 29

1 hours, better. Her appetite had been good. Her
2 focus was okay. Her energy level had been good.
3 No suicidal thoughts, because there was a
4 question mark of whether the medicine was
5 working or not, and also we increased the dose
6 to 20-milligrams and to be taken with food.

7 Q. Based on what Maricel told you at
8 that September meeting, September 2013, did you
9 believe that the medicine was working?

10 A. I said there was a question mark if
11 you look at the bottom of the page whether there
12 were any changes from the medication yet.

13 Q. So if it wasn't the medication, what
14 would you attribute what she reported in terms
15 of her sleeping, not crying, and appetite? How
16 would you attribute that, if not to the
17 medication?

18 A. Well, anxiety -- again, this is pure
19 speculation, as it happened a long time ago.
20 Anxiety can wax and wane, people can feel better
21 for short periods. They cycle up and down.

22 Q. Does that also mean that people with
23 anxiety can also feel increased anxiety or dips
24 in mood without a particular trigger?

8 (Pages 26 to 29)

<p style="text-align: right;">Page 30</p> <p>1 A. That's a very -- I am going to answer 2 you this way: Once somebody has a known anxiety 3 disorder, anxiety can come and go without -- 4 once you have established anxiety, there are 5 triggers which obviously make it worse and 6 things which can make it better, but anxiety and 7 depression, for that matter, can come and go 8 once you have an established pattern of anxiety 9 without there being triggers.</p> <p>10 Q. Did Maricel have an established 11 pattern of anxiety?</p> <p>12 A. I wouldn't want to say that. I had 13 only known her a month at that point. She 14 definitely had -- she had anxiety symptoms, yes, 15 but was she a patient like I have just described 16 who for years has suffered from anxiety, no, but 17 again, we are speculating here. I want to stick 18 to what Maricel.</p> <p>19 Q. I understand, and I am not trying to 20 ask you things -- I am not asking you to state 21 anything you don't recall about Maricel.</p> <p>22 I am trying to educate myself a bit 23 on what these conditions mean.</p> <p>24 A. Sure.</p>	<p style="text-align: right;">Page 32</p> <p>1 Again, I am going to stick to what is 2 on my notes, because I would be speculating.</p> <p>3 Q. So I asked you whether you developed 4 any impression of what her experience was like 5 in the Rush program.</p> <p>6 A. I thought we have covered that. You 7 know, she had a bad -- you know, she had two bad 8 evals, she had got written up. I don't, you 9 know, those are the facts.</p> <p>10 Q. Well, those are what she explained to 11 you?</p> <p>12 A. Hmm-hmm.</p> <p>13 Q. You didn't have any independent 14 understanding of outside of what she told you 15 about what her experience was in the program; 16 correct?</p> <p>17 A. Well, again, I want to stick with 18 what is written here, because this was 2013. I 19 can't remember. I mean --</p> <p>20 Q. I am just asking whether you knew 21 anything about Maricel's experience in the 22 program aside from what she told you?</p> <p>23 A. That would be -- you know, I treated 24 a lot of Rush students in all different -- and</p>
<p style="text-align: right;">Page 31</p> <p>1 Q. So adjustment disorder, that is a 2 distinct disorder from an anxiety disorder?</p> <p>3 A. Correct. Well, it is an adjustment 4 reaction with anxiety, which is separate from 5 like a panic disorder or a generalized anxiety 6 disorder, which isn't brought on by a stressor.</p> <p>7 Q. I have another question about the 8 September meeting.</p> <p>9 Was that the expected lag time 10 between her first and second visits to you? The 11 first one was August 15, 2013, and the second 12 one was September 6th.</p> <p>13 A. Yes, usually I will when starting a 14 patient on medication, I will usually see them 15 within two to three weeks of starting that 16 medicine, and she certainly came back within two 17 to three weeks. I even have 18 to 19 days.</p> <p>18 Q. By the end of the September meeting 19 with Maricel, had you developed an impression of 20 what Maricel's experience was like in the 21 program at Rush?</p> <p>22 A. These follow-up visits were 20 to 30 23 minutes long. They weren't extensive meetings 24 like the first meeting.</p>	<p style="text-align: right;">Page 33</p> <p>1 so I would be totally -- you are asking me to 2 remember something from being 2018 from 3 four-and-a-half, you know, years ago, and I 4 can't do that.</p> <p>5 Q. Did you ever review records from 6 Maricel's academic file from Rush?</p> <p>7 A. No.</p> <p>8 Q. Did you ever speak with any of her 9 clinical instructors at Rush?</p> <p>10 A. No.</p> <p>11 Q. Did you ever hear thirdhand or 12 secondhand about Maricel's reputation in the 13 program from people other than Maricel?</p> <p>14 A. Not that I can recall.</p> <p>15 Q. Were you in touch with anyone from 16 the Nurse Anesthesia Program at the time you 17 were treating Maricel?</p> <p>18 A. No.</p> <p>19 Q. When you were treating patients who 20 were students that had been referred by 21 Dr. Terebessy, did you usually give any kind of 22 update to Dr. Terebessy?</p> <p>23 A. Sometimes, yes.</p> <p>24 Q. Do you recall doing that with</p>

<p style="text-align: right;">Page 34</p> <p>1 Maricel?</p> <p>2 A. I don't recall.</p> <p>3 Q. Did Dr. Terebessy give you updates</p> <p>4 when you were treating the same patient as well?</p> <p>5 I mean, generally speaking?</p> <p>6 A. I would say it is probable, but I</p> <p>7 don't recall.</p> <p>8 Q. Well, I understand that Dr. Terebessy</p> <p>9 referred many patients to you when you were</p> <p>10 serving as the psychiatrist for Rush students</p> <p>11 through the Counseling Center.</p> <p>12 Was it -- was it typical that you and</p> <p>13 Dr. Terebessy would have no contact after that</p> <p>14 referral about a student as if you were both</p> <p>15 treating the student, or was it more typical</p> <p>16 that you would periodically touch base?</p> <p>17 A. We would certainly touch base if</p> <p>18 there were issues and problems with that</p> <p>19 student.</p> <p>20 Certainly, if a student came to me</p> <p>21 and they were suicidal or I had to do something</p> <p>22 urgently, I would touch base with her.</p> <p>23 She would touch base with me if there</p> <p>24 were specific concerns she had about students,</p>	<p style="text-align: right;">Page 36</p> <p>1 There was no imminent urgent thing.</p> <p>2 I can't recall whether I spoke with</p> <p>3 Dr. Terebessy or not.</p> <p>4 Again, I would be speculating if I</p> <p>5 said her leave of absence would make me call her</p> <p>6 afterwards.</p> <p>7 BY MS. COURTHEOUX:</p> <p>8 Q. Did you and Dr. Terebessy when you</p> <p>9 compared sort of notes on students that you were</p> <p>10 both treating, did you generally agree on things</p> <p>11 like diagnoses and treatment plans?</p> <p>12 A. I would say the majority of the times</p> <p>13 we agreed. I wouldn't say we agreed with every</p> <p>14 patient.</p> <p>15 Q. Let's move on to the next</p> <p>16 appointment, which was October 12th, 2013,</p> <p>17 according to your notes on Page 6.</p> <p>18 If you could tell us what happened on</p> <p>19 October 12th, please.</p> <p>20 A. Sure. So she was -- Maricel was</p> <p>21 taking Celexa 20-milligrams a day. Side</p> <p>22 effects, the twitching had gone away, but still</p> <p>23 got queasy in the morning.</p> <p>24 She was not feeling depressed.</p>
<p style="text-align: right;">Page 35</p> <p>1 but for students who would seem to be doing</p> <p>2 okay, we wouldn't have regular contact on them,</p> <p>3 no. Except maybe once a year, we would get</p> <p>4 together once or twice a year, we would get</p> <p>5 together and go over just in general the --</p> <p>6 where students were.</p> <p>7 Q. Do you have notes from those once or</p> <p>8 twice a year meetings with Dr. Terebessy?</p> <p>9 A. No.</p> <p>10 Q. Do you recall speaking with</p> <p>11 Dr. Terebessy about Maricel after the initial</p> <p>12 referral?</p> <p>13 A. I don't recall.</p> <p>14 Q. Based on your notes of what you</p> <p>15 discussed with Maricel, do you believe Maricel</p> <p>16 would fall into the category of students who you</p> <p>17 would have touched base with Dr. Terebessy after</p> <p>18 the initial referral or the category of students</p> <p>19 who you more likely would not have?</p> <p>20 MS. SIEGEL: I am going to object to the</p> <p>21 lack of foundation.</p> <p>22 THE WITNESS: Again, the fact that she was</p> <p>23 going to go on a leave of absence, that's a</p> <p>24 serious thing, but there was no suicidality.</p>	<p style="text-align: right;">Page 37</p> <p>1 Anxiety was decreased, doesn't feel as rattled,</p> <p>2 but not in the situation.</p> <p>3 Improvement with other -- I think</p> <p>4 that says improvement with other stomach GI</p> <p>5 symptoms, I think.</p> <p>6 Sleeping okay, appetite okay, energy</p> <p>7 okay, focus okay. Having some fun, went on a</p> <p>8 trip, went driving, actually enjoyed it, not</p> <p>9 anxious by -- I have to take this. Sorry.</p> <p>10 (Short break in proceedings.)</p> <p>11 BY MS. COURTHEOUX:</p> <p>12 Q. Are you able to continue?</p> <p>13 A. Yes.</p> <p>14 Q. I believe we left off --</p> <p>15 A. Actually enjoyed it, not anxious</p> <p>16 by -- I can't read the next two words.</p> <p>17 Irritable negative, no suicidal</p> <p>18 ideation, can tolerate the queasiness.</p> <p>19 Her mental status exam, her affect</p> <p>20 was full range, and continue present management.</p> <p>21 Q. Can you explain that MSE something</p> <p>22 exam that you mentioned?</p> <p>23 A. Well, that's a typical -- any</p> <p>24 psychiatric exam, you do a mental status exam,</p>

Page 38

1 and her affect is how she looked, and she had a
2 full range of affect, meaning, there was no
3 obvious sadness or anxiety or -- just was
4 normal.

5 Q. So it looks like it had been between
6 maybe about five weeks since her last
7 appointment when she came in in October 2013?

8 A. Right.

9 Q. Would that have been an expected
10 length of time since the last appointment?

11 A. Yes.

12 Q. Up above you wrote, anxiety has
13 decreased, don't feel as rattled, but not in the
14 situation.

15 Can you explain what you meant by
16 that?

17 A. Again, I am guessing, but not in the
18 -- I think Maricel was now on leave, so she
19 wasn't in the nursing program.

20 Q. So in your view, by October 2013,
21 treatment was going well for Maricel? Would you
22 say that?

23 A. I would say she was doing better,
24 yes.

Page 39

1 Q. You would say she was making
2 appropriate progress?

3 A. Yes.

4 Q. Could you tell at this point if the
5 medication was working?

6 A. I mean, it did appear -- I mean, she
7 appeared to be better, so the medication could
8 be working, yes.

9 Q. Okay. Let's go to the next one,
10 please. When was Maricel's next visit?

11 A. On February 12 of 2014.

12 Q. And we are on Page 7; correct?

13 A. Yes.

14 Q. Okay. Could you walk us through what
15 happened on February 12th, please?

16 A. It says she was still taking Celexa,
17 20-milligrams a day.

18 I have an arrow that I made, so I
19 would like to do that first just so it makes
20 more sense.

21 Q. Okay.

22 A. Don't feel that it is because of my
23 anxiety. It is because of what I am up against.
24 I am going against the buddy system. They want

Page 40

1 you to quit.

2 Able to sleep, appetite okay, but a
3 -- something secondary to stress. I can't read
4 that.

5 Energy okay, focus at times down
6 because sleep is inadequate, no insomnia. She
7 had no insomnia, which means she could fall
8 asleep but doesn't get enough sleep, not
9 irritable, no anhedonia, felt better with family
10 and husband, no suicidal thoughts, occasionally
11 wakes up in the middle of the night, anxious
12 secondary to -- I can't read that, and then
13 going back to the first paragraph, plus going
14 back to school, question, when will get kicked
15 out of school. That's leading to increased
16 stress. Waiting to hear from the dean and vice
17 provost. Hopes are lower of passing or
18 something. Feels that not being treated fairly,
19 feels like -- feels like there is no system,
20 feels that being bullied.

21 Q. Did you expect there to be four
22 months between Maricel's October visit and her
23 next visit after that?

24 A. It is customary at Rush when students

Page 41

1 go on leave that I no longer am the treating
2 doctor, because Rush, when they go on leave,
3 Rush doesn't cover it, and so when they go on
4 leave, they have to make other arrangements for
5 their care. So it would not be unusual that I
6 didn't see her while she was on leave.

7 Q. Are you aware whether Maricel made
8 other arrangements to meet with a psychiatrist
9 while she was on leave?

10 A. I am not aware. I don't know.

11 Q. Do you recall offering her any
12 suggestions of who to see if she couldn't see
13 you because she wasn't -- because she was on a
14 leave of absence?

15 A. I don't recall that.

16 Q. What is anhedonia?

17 A. She had no anhedonia, which means she
18 could still enjoy things.

19 Q. Is it fair to say that Maricel talked
20 to you substantially about her experience in the
21 program at this February visit?

22 A. Well, she did talk about the program,
23 yes.

24 Q. Did she tell you why she felt she was

11 (Pages 38 to 41)

Page 42

1 at risk of getting kicked out of school?

2 A. Well, as I said, she didn't feel that
3 it was because of her anxiety. She said that it
4 was what she was up against. She was up against
5 a buddy system. She said they just wanted you
6 to quit. The exact reason why, no, I don't have
7 that documented.

8 Q. Looking back now, do you have any
9 impression of why she was concerned about her
10 ability to complete the program, concerned that
11 she might get kicked out of the program?

12 A. Could you repeat the question,
13 please.

14 MS. COURTHEOUX: Could you read it back,
15 please.

16 (Record read.)

17 THE WITNESS: She certainly expressed her
18 concerns about getting kicked out of the
19 program, whether she would pass or graduate from
20 the program. She said anxiety wasn't the
21 problem. It was what the system she was up
22 against.

23 BY MS. COURTHEOUX:

24 Q. Is it consistent with what you recall

Page 44

1 and there.

2 Q. So you formed no impression about
3 what Maricel's issues in the program were that
4 were leading her to be in jeopardy of being
5 dismissed?

6 A. Could you repeat that, please?

7 MS. COURTHEOUX: Would you please read it
8 back?

9 (Record read.)

10 THE WITNESS: Again, as I said, I told you
11 that I knew she had been written up, she had two
12 bad evaluations, but the exact reasons why, no,
13 but I have also said that she said that she was
14 up against a system, that they wanted her to
15 quit.

16 So the -- it is -- I have a little
17 bit of information about what she did, certainly
18 not the whole picture, and I have some
19 information of -- that she reported of the
20 system that she was up against, the buddy
21 system, and wanting her to quit. That's about
22 all I know.

23 BY MS. COURTHEOUX:

24 Q. What was the buddy system?

Page 43

1 about Maricel that she was getting kicked out of
2 school or at risk of getting kicked out of
3 school because of misconduct like theft or
4 acting out?

5 A. Can you repeat that?

6 MS. COURTHEOUX: Can you repeat that,
7 please.

8 (Record read.)

9 MS. SIEGEL: I am going to object to the
10 form of the question, assumes facts not in
11 evidence.

12 THE WITNESS: If you are referring to theft
13 or misconduct, there is nothing that I am aware
14 of from these notes. Misconduct is a very broad
15 word.

16 BY MS. COURTHEOUX:

17 Q. As you sit here today, is it a great
18 mystery to you why Maricel was in jeopardy of
19 being kicked out of the program when you were
20 treating her?

21 A. As I said earlier -- as we said
22 earlier, I did not have access to her academic
23 records. I did not speak to her professors or
24 advisors. I have snippets of information here

Page 45

1 A. Again, this is speculation, total
2 speculation. I am kind of having a problem
3 here, because I have seen other students from
4 this program, and so I cannot reveal other
5 information without their consent.

6 Q. I haven't asked you about any other
7 patients specifically. I am just asking you
8 what you meant when you wrote the "buddy
9 system."

10 A. What I think can happen is there can
11 be a couple of instructors who decide, you know,
12 you don't fit into our country club, and then
13 they kind of gun for you after that and they can
14 make your life very difficult.

15 Q. Is it your belief that that's -- that
16 that actually happened to Maricel in the
17 program?

18 A. Again, I said I was talking in
19 general. I cannot say that that happened to
20 Maricel specifically.

21 You asked me to extrapolate on that,
22 and I did, and whether I can say that exactly
23 happened to Maricel, of course I can't, but that
24 is what I know can happen.

Page 46

Page 48

Q. So here is it fair to say that you were just reporting what she subjectively felt was going on; that she felt subjectively like she was being bullied?

A. I am not sure where you get the word "bullied." Oh, yes, fear of being bullied, yes. Feels like there is no system, fear that she is being bullied, yes.

Q. Is that true also when you say, "going against the buddy system," is it that Maricel felt she was going against this buddy system, or were you reporting that you believed she was going against the buddy system?

A. No, this is what she reports to me. I don't feel that it is because of my anxiety. It is because of what I am up against. I am going against the buddy system. They want you to quit.

Q. Thank you. What -- who did you -- excuse me. Strike that.

Who is "they" when you have written, "they want you to quit"? Who did she feel wanted her to quit?

A. Her instructors, her nursing

pain?

A. Again, if it is not documented, then I cannot comment.

Q. If she was in physical pain, is it your practice normally to include that in your notes?

A. Yes, if she complained of it, yes.

Q. I just have one more question about your notes, Dr. Kreiner.

A. Sure.

Q. We are going back to the initial visit.

A. Yes.

Q. This should be around Page 3, I think -- I am sorry, Page 4.

You indicated patient wants to be on medication. I am not sure if medication is indicated. Is that accurate?

A. Yes.

Q. Can you explain that?

A. Sometimes with adjustment disorders, they can get better with therapy alone, and -- or they can get better with therapy and medication, and in this case, I clearly was on

Page 47

Page 49

instructors, professors.

Q. Did Maricel mention worrying about how she would be perceived by her peers if she was dismissed from the program?

A. By her peers? If I didn't comment on it before in my notes, then no. We went through my notes. If I didn't comment on it before, then the answer is no.

Q. Did Maricel complain to you of any physical injury?

A. Not that I have documented, no.

Q. Is that something you would have documented if she reported it to you?

A. What sort of a physical injury are we talking about?

Q. Really any physical injury. I haven't heard -- based on your notes, I haven't seen anything in here about any physical injury, only physical conditions, emotional conditions.

A. I would certainly say that it is my practice if somebody reports a physical injury that if it is of any significance, I would make documentation of that.

Q. Did Maricel complain to you of any

the fence, but because Maricel wanted to take medicine, I agreed, and I wouldn't have agreed if I wasn't on the fence.

So I could have gone either way, and because she requested it, I agreed. If I had thought it was not indicated at all, then it would be malpractice to give somebody medicine.

Q. Why did Maricel want to take medication?

A. I would be -- you know, I don't have it written down why.

Again, I would be speculating that -- it is pure speculation that she felt that taking medicine would help her anxiety symptoms.

Q. Just one more set of questions, and then I am all through.

A. Sure.

Q. You received a subpoena from us around November 1st, 2017 for documents; is that right?

A. That's correct.

Q. And I called you a few weeks after that to see when we could expect to receive documents from you; is that right?

Page 50	Page 52
<p>1 A. That's correct.</p> <p>2 Q. Was that on November 20th, 2017?</p> <p>3 A. If you say so.</p> <p>4 Q. And at that time, I mentioned which</p> <p>5 patient was the plaintiff in the case; is that</p> <p>6 right, which you also knew from the subpoena?</p> <p>7 A. Yes.</p> <p>8 Q. And I said that I represented the</p> <p>9 defendants, including Rush University Medical</p> <p>10 Center; is that right?</p> <p>11 A. Yes.</p> <p>12 Q. What did you say then when we spoke</p> <p>13 on the phone?</p> <p>14 A. I don't recall, but maybe you can</p> <p>15 remind me.</p> <p>16 Q. Didn't you say, "I feel sorry for</p> <p>17 you"?</p> <p>18 A. In connection with what?</p> <p>19 Q. When I asked what you meant, did you</p> <p>20 say, "Some people just can't accept it when they</p> <p>21 fail"?</p> <p>22 A. I am not sure what you are referring</p> <p>23 to.</p> <p>24 Q. I am referring to our phone</p>	<p>1 MS. COURTHEOUX: Okay. That's it for me.</p> <p>2 MS. SIEGEL: I just have a few follow-up</p> <p>3 questions. Thank you for coming and thank you</p> <p>4 for walking us through your notes. I had</p> <p>5 difficulty trying to interpret them and you have</p> <p>6 been very helpful.</p> <p>7 EXAMINATION</p> <p>8 BY MS. SIEGEL:</p> <p>9 Q. Now, we have gone over a period of</p> <p>10 time stretching from August of 2013 through</p> <p>11 February of 2014 when you were in contact with</p> <p>12 Ms. Marcial; is that right?</p> <p>13 A. That's correct.</p> <p>14 Q. And during that time period, did you</p> <p>15 have an opportunity to form an opinion as to</p> <p>16 whether Ms. Marcial were in touch with reality?</p> <p>17 A. Do you mean whether I believed she</p> <p>18 was psychotic? Because psychotic, you know, in</p> <p>19 psychiatry we have are you psychotic, which</p> <p>20 means -- "out of reality" is a very broad term.</p> <p>21 She was not psychotic, meaning there</p> <p>22 was no evidence of any delusions or</p> <p>23 hallucinations, so she was not psychotic at any</p> <p>24 time when I saw her.</p>
Page 51	Page 53
<p>1 conversation on November --</p> <p>2 A. Yeah, I know, but I am not sure what</p> <p>3 that means, what you have just said.</p> <p>4 Q. Well, I am just reminding you what I</p> <p>5 recall you saying, and asking you whether that</p> <p>6 is accurate?</p> <p>7 A. I mean, if you say I said it, I said</p> <p>8 it. I don't recall in what context I said it.</p> <p>9 Q. As you sit here today, can you think</p> <p>10 of any reason you would have said, "Some people</p> <p>11 just can't accept it when they fail" with</p> <p>12 respect to Maricel's case?</p> <p>13 A. I think you drew the wrong conclusion</p> <p>14 from what I said. I certainly -- that's not --</p> <p>15 that does not sound -- that is certainly not --</p> <p>16 I wasn't referring to -- I certainly would not</p> <p>17 stand here today and say that, not the way you</p> <p>18 are saying it.</p> <p>19 Q. Could you clarify what you meant</p> <p>20 then?</p> <p>21 A. I mean, these are just -- I really</p> <p>22 don't recall.</p> <p>23 Q. So you don't recall saying that?</p> <p>24 A. No.</p>	<p>1 Q. Did you have a perception of the</p> <p>2 caliber of her perceptions from the facts she</p> <p>3 was discussing with you?</p> <p>4 A. Sorry?</p> <p>5 Q. You can hear me now?</p> <p>6 A. Yes, I can hear you.</p> <p>7 Q. Okay. Did you have a perception as</p> <p>8 to the accuracy with which Ms. Marcial was able</p> <p>9 to relate to you facts and circumstances</p> <p>10 pertinent to your work together?</p> <p>11 A. I believed that what she reported is</p> <p>12 accurate, yes.</p> <p>13 Q. Now, in your work with students, did</p> <p>14 you encounter from time to time students who</p> <p>15 failed in their programs?</p> <p>16 A. Yes, I did.</p> <p>17 Q. How often did that happen?</p> <p>18 A. I saw students across all the Rush</p> <p>19 programs, so medical school, nursing school,</p> <p>20 postgraduate nursing school, OT.</p> <p>21 You have got to remember that I see a</p> <p>22 section of the Rush student population, the ones</p> <p>23 who are having psychological/psychiatric issues,</p> <p>24 so they are already a subset of the student</p>

Page 54

1 population, and then of that subset, I certainly
2 encountered a fair amount of students who were
3 having problems, but I would say not a lot of
4 students -- I am going to rephrase.

5 Certainly, I did see students fail or
6 go on leaves of absences or some -- I can't
7 recall how many were asked to leave, and I did
8 this job for ten years or so, so it is a long --
9 it has been awhile since -- so certainly there
10 was some of the students, yes, didn't make it.

11 Q. Now, did you see Ms. Marcial after
12 this February 12, 2014 meeting we have been
13 discussing?

14 A. That's my last recorded note in my
15 chart so I would think not, unless there is some
16 notes that I am missing.

17 Q. Do you have any reason to believe
18 that your notes are incomplete for Ms. Marcial?

19 A. I mean, I would hope not.

20 Q. Okay. Do you try to keep complete
21 and accurate records of your sessions with your
22 patients?

23 A. I try the best I can, yes.

24 Q. Okay. So do you have any knowledge

Page 55

1 from any source of what Ms. Marcial experienced
2 after February 12 of 2014?

3 A. No, because I don't have any further
4 documentation.

5 Q. Do you have any recollection of any
6 discussion with anybody at the university as to
7 what happened to her after that February date?

8 A. Again, this is speculation
9 completely, but I would touch base with
10 Dr. Terebessy, and she would tell me which
11 students were or weren't in the program anymore,
12 and she probably said Maricel is not in the
13 program anymore and she is no longer in the Rush
14 system. That probably would have happened at
15 some point.

16 Q. All right. And do you have any
17 recollection of any facts about the
18 circumstances of Maricel's termination?

19 A. No.

20 Q. All right. Do you have an opinion as
21 to whether it is rational for a student to take
22 issue with facts and circumstances that they
23 perceive to be unjust?

24 A. Can you just repeat that? I want to

Page 56

1 make sure I answered correctly.

2 Q. Sure. Let me have the court reporter
3 repeat it, and I am glad to clarify if you need
4 further information.

5 (Record read.)

6 THE WITNESS: Yes, I do.

7 BY MS. SIEGEL:

8 Q. And what's that opinion?

9 A. That if they feel that circumstances
10 are unjust or unfair, they should be allowed to
11 speak up and speak out, yes.

12 Q. And if students perceive that they
13 have been wrongfully terminated from a program,
14 do you have an opinion as to whether it is
15 appropriate for them to take measures to get
16 redress?

17 A. Yes, of course. If they feel they
18 have been wrongfully terminated, they should
19 feel they have the right to take measures.

20 Q. And the university has some
21 procedures so they can do that; is that right?

22 A. I don't know.

23 Q. All right. And do you know whether
24 accrediting agencies take a look at issues as to

Page 57

1 whether students are treated fairly?

2 A. I know in residency, medical
3 residency programs, they do regular
4 accreditations every number of years to see if
5 residents are being treated fairly. I don't
6 know about nursing programs specifically.

7 Q. And you are aware that there are
8 federal laws that institutions have to comply
9 with; isn't that right?

10 A. If --

11 Q. And by "institutions," I mean
12 academic institutions generally.

13 A. I would assume so, yes.

14 Q. All right. And if a student feels
15 that the law has been violated, wouldn't you
16 agree that it is rational for the student to
17 take some kind of action to come to terms with
18 that?

19 A. Of course.

20 Q. And that could include bringing a
21 lawsuit?

22 A. Of course.

23 Q. And you never had an opportunity to
24 speak with Maricel about why it was that she was

15 (Pages 54 to 57)

<p style="text-align: right;">Page 58</p> <p>1 taking issue with her termination from the Rush 2 program? 3 A. Well, not after she got terminated, 4 no, I have no documentation of that. 5 Q. Now, you testified that you had other 6 students from the student anesthesia program, 7 the student Registered Nurse Anesthesia Program 8 at Rush among your caseload; right? 9 A. Correct. 10 Q. Is there a procedure to go through 11 where you could -- you could disclose 12 information about the circumstances of those 13 students? 14 And I want you to understand, I am 15 not asking you in answer to this question to 16 reveal any confidential information. 17 A. Is there a procedure I could do? 18 Q. Is there a procedure that could -- 19 that the parties could do in order for you to be 20 able to testify about those circumstances? 21 A. Well, no information can be released 22 on other students without their individual 23 consent. 24 Q. Surely.</p>	<p style="text-align: right;">Page 60</p> <p>1 physically examine a patient. 2 Q. That's what I was asking. Thank you. 3 MS. SIEGEL: I have nothing further. 4 MS. COURTHEOUX: I just have one follow-up 5 if you don't mind. 6 THE WITNESS: Sure. 7 FURTHER EXAMINATION 8 BY MS. COURTHEOUX: 9 Q. In response to one of Ms. Siegel's 10 questions, you testified, I believed that what 11 Maricel reported was accurate. Do you recall 12 that? 13 A. Yes. 14 Q. I just want to make sure I 15 understand. Does that mean you believed that 16 there is no system as reported on Page 7? 17 A. No. What -- to clarify, I believed 18 everything Maricel, what she was saying was 19 accurate, meaning, she was -- that was her 20 report, and as a psychiatrist, I have to go by 21 her report. 22 That is what she reported, and I 23 believed that report to be accurate as reported 24 by her.</p>
<p style="text-align: right;">Page 59</p> <p>1 A. And they cannot be identified as -- 2 that was the whole thing about Rush; that this 3 was a confidential setting that others -- that 4 students could come and get -- and that's where 5 Rush was very, very good; that this was a 6 totally confidential place that these -- medical 7 psychiatric treatment would stay completely 8 confidential and never -- they never had to put 9 it on their insurance. 10 Rush provided this service to enable 11 them to get the help they needed, so other 12 students that I have seen, their anonymity 13 absolutely has to be preserved. 14 Q. Sure. You testified about knowledge 15 of physical injury. 16 A. I said I had no knowledge of any 17 physical injury. 18 Q. Right. And my question to you is 19 whether your work as a psychiatrist with 20 Ms. Marcial involved any other -- any other 21 systems apart from -- apart from the 22 psychological symptoms that she reported to you 23 and sought relief for? 24 A. It is not a psychiatrist's job to</p>	<p style="text-align: right;">Page 61</p> <p>1 Q. So in other words, would it be fair 2 to say that you believe that Maricel was 3 accurately reporting her subjective feelings? 4 A. Correct. 5 Q. Not that what she reported was 6 objectively true necessarily? 7 A. She reported what she observed or 8 what she felt, and I believed those observations 9 that she -- the only thing a psychiatrist can do 10 is to go by what the patient says unless you go 11 get further collateral history from other 12 places. 13 So in this case, I am going off what 14 she told me, and she told me and reported things 15 about, for example, the system. That was her 16 perception or her belief of what the situation 17 was at Rush. 18 MS. COURTHEOUX: Thank you. 19 MS. SIEGEL: Just another question or two. 20 THE WITNESS: Yes. 21 22 23 24</p>

<p style="text-align: right;">Page 62</p> <p>1 FURTHER EXAMINATION</p> <p>2 BY MS. SIEGEL:</p> <p>3 Q. You testified that -- I am trying to</p> <p>4 read my notes.</p> <p>5 A. Sure.</p> <p>6 Q. That what can happen, there can be a</p> <p>7 couple of instructors, and they decide you don't</p> <p>8 fit into our country club?</p> <p>9 A. Hmm-hmm.</p> <p>10 Q. They gun for you after that?</p> <p>11 A. Hmm-hmm.</p> <p>12 Q. That can make your life very</p> <p>13 difficult?</p> <p>14 A. Hmm-hmm -- yes.</p> <p>15 Q. Was that a perception that Maricel</p> <p>16 reported to you?</p> <p>17 A. The question was for me to explain</p> <p>18 the buddy system, and when I explained it, I</p> <p>19 said because I have treated many students from</p> <p>20 Rush and also being a student in medical school</p> <p>21 myself, that medical schools are a -- let me</p> <p>22 just stick -- let me not go away.</p> <p>23 You have to conform, medical school</p> <p>24 requires, nursing school, they all require a</p>	<p style="text-align: right;">Page 64</p> <p>1 Ms. Marcial that suggested that she was less</p> <p>2 than fully intact in terms of her presentation</p> <p>3 of self?</p> <p>4 A. No.</p> <p>5 MS. SIEGEL: Nothing further.</p> <p>6 MS. COURTHEOUX: That's all.</p> <p>7 Would you like to read over the</p> <p>8 transcript before you -- and then sign it?</p> <p>9 THE WITNESS: That's okay.</p> <p>10 MS. COURTHEOUX: You just want to waive</p> <p>11 signature?</p> <p>12 THE WITNESS: Yes.</p> <p>13</p> <p>14 DEPONENT FURTHER SAITH NOT</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>
<p style="text-align: right;">Page 63</p> <p>1 certain way you dress, a certain way you behave,</p> <p>2 a certain way you comport yourself, and if you</p> <p>3 don't follow those norms, it is frowned upon and</p> <p>4 it is, as I said, there can be cases of where</p> <p>5 students are -- don't fit into that mold that</p> <p>6 they are looking for, and then instructors can</p> <p>7 say, you know, we don't -- that student,</p> <p>8 whatever, we don't care for that student and</p> <p>9 then they will gun for that student and can make</p> <p>10 their life difficult.</p> <p>11 Again, I am talking in generalities</p> <p>12 across all the students that I have seen.</p> <p>13 Q. Now, isn't one of the things that you</p> <p>14 assess as a psychiatrist when you are working</p> <p>15 with -- when you are working with a client, is</p> <p>16 one of the things that you look at the client's</p> <p>17 physical presentation?</p> <p>18 A. Yes.</p> <p>19 Q. And you observe whether, for example,</p> <p>20 their dress and deportment and self-presentation</p> <p>21 show any signs of a compromised psychiatric</p> <p>22 state?</p> <p>23 A. Yes.</p> <p>24 Q. Did you observe anything with</p>	<p style="text-align: right;">Page 65</p> <p>1 CERTIFICATE OF REPORTER</p> <p>2</p> <p>3 I, TERESA VOLPENTESTA, a Certified</p> <p>4 Shorthand Reporter within and for the County of</p> <p>5 Cook, State of Illinois, do hereby certify:</p> <p>6 That previous to the commencement of</p> <p>7 the examination of the witness, the witness was</p> <p>8 duly sworn to testify the whole truth concerning</p> <p>9 the matters herein;</p> <p>10 That the foregoing deposition</p> <p>11 transcript was reported stenographically by me,</p> <p>12 was thereafter reduced to typewriting under my</p> <p>13 personal direction and constitutes a true record</p> <p>14 of the testimony given and the proceedings had;</p> <p>15 That the said deposition was taken</p> <p>16 before me at the time and place specified;</p> <p>17 That I am not a relative or employee</p> <p>18 or attorney or counsel, nor a relative or</p> <p>19 employee of such attorney or counsel for any of</p> <p>20 the parties hereto, nor interested directly or</p> <p>21 indirectly in the outcome of this action.</p> <p>22</p> <p>23</p> <p>24</p>

Page 66

1 IN WITNESS WHEREOF, I do hereunto set
2 my hand and affix my seal of office at Chicago,
3 Illinois this 15th day of March, 2018.
4
5
6
7

8 _____
9 TERESA VOLPENTESTA.
10 C.S.R. Certificate No. 84-2781.
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20
21
22
23
24

18 (Page 66)

<p>A</p> <p>ability 42:10</p> <p>able 28:7,13 37:12 40:2 53:8 58:20</p> <p>above-entitled 1:12</p> <p>absence 18:4 22:6 25:9 35:23 36:5 41:14</p> <p>absences 54:6</p> <p>absolutely 26:15 59:13</p> <p>academic 33:6 43:22 57:12</p> <p>accept 50:20 51:11</p> <p>access 43:22</p> <p>accreditations 57:4</p> <p>accrediting 56:24</p> <p>accuracy 53:8</p> <p>accurate 48:18 51:6 53:12 54:21 60:11,19,23</p> <p>accurately 11:23 61:3</p> <p>acting 43:4</p> <p>action 1:5 10:13 57:17 65:21</p> <p>acute 17:10</p> <p>address 8:1 15:3,20</p> <p>adjustment 20:7 24:23 25:4 31:1,3 48:21</p> <p>advance 14:17</p> <p>advisors 43:24</p> <p>affect 37:19 38:1,2</p> <p>affix 66:2</p> <p>Africa 6:17</p> <p>agencies 56:24</p> <p>ago 11:21 13:17 24:21 29:19 33:3</p> <p>agree 36:10 57:16</p> <p>agreed 36:13,13 49:2,2,5</p> <p>ahead 6:5</p> <p>al 1:7</p> <p>allergies 16:17</p> <p>allowed 56:10</p> <p>amount 54:2</p>	<p>analysis 8:9</p> <p>anesthesia 15:9 16:2 33:16 58:6,7</p> <p>anhedonia 40:9 41:16,17</p> <p>anonymity 59:12</p> <p>anorexia 20:2</p> <p>answer 5:1,12 6:4 24:5,5,19 30:1 47:8 58:15</p> <p>answered 56:1</p> <p>answering 4:23 5:23</p> <p>answers 5:10</p> <p>anxiety 17:1 18:9 18:10,16,17 19:21 20:8,23,24 22:14 23:3 24:13,24 25:2,4,5 26:22 27:10,15 29:18,20 29:23,23 30:2,3,4 30:6,8,11,14,16 31:2,4,5 37:1 38:3 38:12 39:23 42:3 42:20 46:15 49:14</p> <p>anxious 17:12,18 17:23 19:5 21:8 21:23 22:1,2,14 37:9,15 40:11</p> <p>anybody 55:6</p> <p>anymore 28:24 55:11,13</p> <p>apart 59:21,21</p> <p>appear 39:6</p> <p>APPEARANCES 2:1</p> <p>appeared 39:7</p> <p>appears 21:7</p> <p>appetite 19:1,5 21:8,22 22:2 28:8 29:1,15 37:6 40:2</p> <p>appointment 23:18 27:22 36:16 38:7 38:10</p> <p>appropriate 39:2 56:15</p> <p>arising 7:22</p> <p>arrangements 41:4</p>	<p>41:8</p> <p>arrow 39:18</p> <p>arrows 18:17</p> <p>aside 32:22</p> <p>asked 5:24 16:13 16:16,17 32:3 45:6,21 50:19 54:7</p> <p>asking 14:21 25:22 30:20 32:20 33:1 45:7 51:5 58:15 60:2</p> <p>asleep 40:8</p> <p>assess 63:14</p> <p>assessed 20:7</p> <p>ASSOC 2:3</p> <p>assume 5:13 57:13</p> <p>assumes 43:10</p> <p>ate 28:11</p> <p>attorney 65:18,19</p> <p>attribute 29:14,16</p> <p>audibly 5:1</p> <p>August 12:2 13:6 31:11 52:10</p> <p>aunt 16:24</p> <p>aware 41:7,10 43:13 57:7</p> <p>awhile 14:4 19:11 54:9</p> <p>A.D 1:19</p> <p>a.m 28:7</p> <p>B</p> <p>B 1:11 3:3,11 4:2</p> <p>back 9:13 14:22 19:2,6 20:16 21:24 22:3,5,14 24:2,7 27:2 28:13 28:14 31:16 40:13 40:14 42:8,14 44:8 48:11</p> <p>bad 18:6 22:15 26:7 26:17 32:7,7 44:12</p> <p>base 34:16,17,22,23 35:17 55:9</p> <p>based 26:1 29:7 35:14 47:17</p>	<p>basically 8:2</p> <p>behalf 2:7,12</p> <p>behave 63:1</p> <p>belief 45:15 61:16</p> <p>believe 10:9,19 14:4 29:9 35:15 37:14 54:17 61:2</p> <p>believed 25:7 46:12 52:17 53:11 60:10 60:15,17,23 61:8</p> <p>benefit 27:11</p> <p>benefits 20:13 27:7</p> <p>best 54:23</p> <p>better 20:8 29:1,20 30:6 38:23 39:7 40:9 48:22,23</p> <p>bipolar 16:22 27:20</p> <p>birth 15:3,20</p> <p>bit 30:22 44:17</p> <p>BLACKWELL 2:8</p> <p>board 8:19</p> <p>bothersome 28:10</p> <p>bottom 24:12 29:11</p> <p>Boulevard 2:3</p> <p>brackets 19:8 24:8</p> <p>break 5:17 6:1 37:10</p> <p>breast 16:11</p> <p>bringing 57:20</p> <p>broad 43:14 52:20</p> <p>brother 17:3</p> <p>brought 11:13 31:6</p> <p>buddy 39:24 42:5 44:20,24 45:8 46:10,11,13,17 62:18</p> <p>bulimia 20:2</p> <p>bullied 40:20 46:4 46:6,6,8</p> <p>C</p> <p>C 65:1,1</p> <p>caliber 53:2</p> <p>call 6:3 13:19 36:5</p> <p>called 4:3 7:19 10:2 10:4,9 13:23 49:22</p> <p>Calls 22:7</p>	<p>capacity 9:10,21 10:5</p> <p>Cape 6:17</p> <p>care 17:10 41:5 63:8</p> <p>case 4:12 10:8 11:21 13:21 25:16 25:21 48:24 50:5 51:12 61:13</p> <p>caseload 58:8</p> <p>cases 4:13 63:4</p> <p>category 35:16,18</p> <p>cause 1:12 27:16</p> <p>causing 25:2</p> <p>Celexa 20:11 27:5,7 27:8 28:2 36:21 39:16</p> <p>Center 1:7 13:10 34:11 50:10</p> <p>certain 11:11 23:15 63:1,1,2</p> <p>certainly 17:18 31:16 34:17,20 42:17 44:17 47:20 51:14,15,16 54:1 54:5,9</p> <p>Certificate 66:9</p> <p>certified 8:19 65:3</p> <p>certify 65:5</p> <p>changes 28:20 29:12</p> <p>characterize 17:16 25:6</p> <p>chart 54:15</p> <p>checked 20:5</p> <p>Chicago 1:18 2:4,9 7:11 66:2</p> <p>cigarettes 16:18</p> <p>circle 9:13</p> <p>circumstances 6:9 53:9 55:18,22 56:9 58:12,20</p> <p>Civil 1:5,15</p> <p>clarify 51:19 56:3 60:17</p> <p>clear 26:22</p> <p>clearly 48:24</p> <p>Cleveland 6:21</p>
--	---	---	--	---

client 63:15 client's 63:16 clinical 17:1 23:22 33:9 club 45:12 62:8 collateral 61:11 come 5:20 23:5 30:3,7 57:17 59:4 comes 26:23 coming 19:6 21:24 22:3,5,14 52:3 commencement 65:6 comment 23:10 47:5,7 48:3 commonly 27:10 compared 36:9 comparisons 20:21 complain 47:9,24 complained 48:7 complete 5:10 42:10 54:20 completely 55:9 59:7 comply 57:8 comport 63:2 compromised 63:21 compulsory 6:19 concerned 42:9,10 concerning 65:8 concerns 34:24 42:18 conclusion 51:13 conditions 26:12 30:23 47:19,19 confidential 58:16 59:3,6,8 conform 62:23 connection 50:18 consent 45:5 58:23 consistent 42:24 constitutes 65:13 consultation 7:7,15 contact 15:4,21 34:13 35:2 52:11 context 51:8 continue 12:14	37:12,20 contributing 26:13 conversation 23:16 51:1 Cook 1:14 65:5 correct 11:1,4 15:22 31:3 32:16 39:12 49:21 50:1 52:13 58:9 61:4 correctly 16:23 56:1 counsel 65:18,19 Counseling 13:10 34:11 counselor 15:6,7 country 45:12 62:8 County 1:14 65:4 couple 7:13 20:20 22:16 45:11 62:7 course 5:8 11:15 45:23 56:17 57:19 57:22 courses 8:8 court 1:1 5:5 56:2 COURTHEOUX 2:11 3:4,6 4:7 12:22 13:4 22:10 36:7 37:11 42:14 42:23 43:6,16 44:7,23 52:1 60:4 60:8 61:18 64:6 64:10 Courts 1:16 cover 15:2 41:3 covered 32:6 crawling 17:13 Crohn's 18:5 crying 19:11 28:24 29:15 current 28:12 customary 13:18 40:24 CV 6:16 cycle 29:21 C.S.R 66:9	date 15:3,20 55:7 day 1:18 36:21 39:17 66:3 days 19:14,15 21:5 28:2,18 31:17 dean 40:16 decide 45:11 62:7 decision 14:11,13 decrease 19:12 decreased 37:1 38:13 defendants 1:8 2:12 50:9 definitely 10:20 30:14 degree 6:18 delusions 52:22 denied 16:17 DEPONENT 64:14 deportment 63:20 deposition 1:11 4:11,21 10:17,23 13:1 65:10,15 depositions 9:14,20 10:2 depressed 36:24 depressing 28:16 depression 16:21 19:21 27:10,16 30:7 describe 9:2 described 26:12 30:15 developed 31:19 32:3 diagnoses 36:11 different 32:24 difficult 6:9 45:14 62:13 63:10 difficulty 52:5 diploma 8:13 dips 29:23 direction 65:13 directly 65:20 discipline 8:23 disclose 58:11 discussed 35:15 discussing 53:3	54:13 discussion 21:22 55:6 dismissed 44:5 47:4 disorder 16:22 20:6 20:7 24:23 25:5 30:3 31:1,2,2,5,6 disorders 48:21 distinct 31:2 District 1:1,1,16 DIVISION 1:2 doctor 6:17 17:11 41:2 documentation 47:23 55:4 58:4 documented 13:22 23:11 42:7 47:11 47:13 48:2 documents 11:2,6 12:18 49:19,24 doing 19:12 23:23 33:24 35:1 38:23 dose 17:11,14,15,16 17:17,19 29:5 Dr 4:8 10:22 13:11 13:12,14,23 15:21 33:21,22 34:3,8 34:13 35:8,11,17 36:3,8 48:9 55:10 drank 16:18 dress 63:1,20 drew 51:13 driving 37:8 drug 16:16 27:3,12 drugs 16:19 17:3 duly 4:1,4 65:8 dysfunction 27:18	eight 28:24 either 12:12 23:1,6 49:4 ELAINE 2:3,6 embarrassed 19:6 19:17 22:18 23:2 23:4 24:9 embarrassment 22:23 emergency 5:19 15:4,21 emotional 47:19 employee 65:17,19 enable 59:10 encounter 12:3 53:14 encountered 54:2 ended 7:9 energy 19:14 29:2 37:6 40:5 enjoy 41:18 enjoyed 37:8,15 episodes 19:20 established 30:4,8 30:10 et 1:7 evals 18:6 26:7 32:8 evaluation 23:23 evaluations 13:13 26:17 44:12 evidence 43:11 52:22 exact 25:24 42:6 44:12 exactly 10:11 12:13 21:4,4 45:22 exam 37:19,22,24 37:24 examination 4:6 52:7 60:7 62:1 65:7 examine 60:1 examined 4:4 example 20:23 61:15 63:19 exams 8:10 excuse 46:20 Exhibit 12:23 13:2
--	---	--	---	--

expect 40:21 49:23 expected 31:9 38:9 expel 18:15 experience 31:20 32:4,15,21 41:20 experienced 55:1 expert 9:21 10:2,7 10:10 explain 8:5 11:5 27:6 37:21 38:15 48:20 62:17 explained 20:12 32:10 62:18 expressed 22:17 42:17 extensive 31:23 extra 7:6 extrapolate 45:21 eye 28:4	feeling 22:17 36:24 feelings 61:3 feels 40:18,19,19,20 46:7 57:14 fellowship 7:6 felt 14:16 17:12 19:6,11 28:10,11 40:9 41:24 46:2,3 46:11 49:13 61:8 fence 49:1,3 fields 8:8 file 11:8,11,13 33:6 fine 4:24 finish 4:22 5:23 first 4:3,20 11:19 12:2 13:5,15 14:15,24 15:15,17 16:6 23:8 27:4 31:10,11,24 39:19 40:13 firstly 16:10 fit 45:12 62:8 63:5 five 4:15 7:10 8:7 9:15,17,19 10:10 18:19 38:6 floor 7:24 focus 19:10 29:2 37:7 40:5 follow 63:3 follows 4:5 15:13 follow-up 31:22 52:2 60:4 follow-ups 7:14 food 28:11 29:6 force 18:22,24 foregoing 65:10 form 43:10 52:15 formal 7:8 formed 44:2 foundation 35:21 four 18:19 40:21 fourth 26:4 four-and-a-half 33:3 frowned 63:3 fulfill 8:12 full 5:9 37:20 38:2 fully 64:2	fun 37:7 further 22:22 55:3 56:4 60:3,7 61:11 62:1 64:5,14	ground 4:18,20 guessing 38:17 gun 45:13 62:10 63:9	husband 40:10 HUSCH 2:8 hypermania 20:3
F 65:1,1 fact 35:22 facts 10:7 32:9 43:10 53:2,9 55:17,22 fail 50:21 51:11 54:5 failed 53:15 fair 19:14 26:18,20 41:19 46:1 54:2 61:1 fairly 40:18 57:1,5 fall 35:16 40:7 familiar 4:19 family 16:20 17:2 40:9 far 21:18 fear 46:6,7 February 39:11,15 41:21 52:11 54:12 55:2,7 federal 1:15 57:8 feel 19:22 28:5 29:20,23 37:1 38:13 39:22 42:2 46:15,22 50:16 56:9,17,19	GI 37:4 give 5:9 27:13,17 27:17 33:21 34:3 49:7 given 65:14 giving 9:22 25:3 glad 56:3 go 4:18 6:5 12:22 16:9,10 30:3,7 35:5,23 39:9 41:1 41:2,3 54:6 58:10 60:20 61:10,10 62:22 going 11:20,23 14:18 16:7 18:3 18:14 19:7,17,18 22:23 23:2 24:8,9 25:9 26:8 30:1 32:1 35:20,23 38:21 39:24 40:13 40:13 43:9 46:3 46:10,11,13,17 48:11 54:4 61:13 GOLDRICH 2:5 good 27:12 28:18 29:1,2 59:5 graduate 19:7 42:19 great 43:17	G gain 27:13 general 7:5,20 8:3 15:12 35:5 45:19 generalities 63:11 generalized 31:5 generally 10:7 13:24 34:5 36:10 57:12 gesture 5:7 gestures 5:2 getting 20:8 22:15 26:17 42:1,18 43:1,2 GI 37:4 give 5:9 27:13,17 27:17 33:21 34:3 49:7 given 65:14 giving 9:22 25:3 glad 56:3 go 4:18 6:5 12:22 16:9,10 30:3,7 35:5,23 39:9 41:1 41:2,3 54:6 58:10 60:20 61:10,10 62:22 going 11:20,23 14:18 16:7 18:3 18:14 19:7,17,18 22:23 23:2 24:8,9 25:9 26:8 30:1 32:1 35:20,23 38:21 39:24 40:13 40:13 43:9 46:3 46:10,11,13,17 48:11 54:4 61:13 GOLDRICH 2:5 good 27:12 28:18 29:1,2 59:5 graduate 19:7 42:19 great 43:17	H H 3:11 habit 23:13 hallucinations 52:23 hand 12:17 66:2 Handwritten 3:14 happen 45:10,24 53:17 62:6 happened 13:21 29:19 36:18 39:15 45:16,19,23 55:7 55:14 happens 14:23 15:1 hard 18:24 headaches 20:4 hear 24:1 33:11 40:16 53:5,6 heard 47:17 held 28:13,14 Hello 4:8,9 help 49:14 59:11 helpful 52:6 hereto 65:20 hereunto 66:1 high 18:16,16,18,18 20:24 27:11 history 8:22 16:11 16:21 17:2,10 20:2,2,3,6 61:11 Hmm-hmm 32:12 62:9,11,14 holding 19:16 24:2 24:7 hope 54:19 Hopes 40:17 hospital 7:20,22 hour 23:18 hours 18:19,21 29:1 humiliated 19:17 23:5 24:9 humiliation 22:23	I ideation 19:19 37:18 identification 13:3 identified 11:6 59:1 Illinois 1:1,14,18 2:4,9 8:15 65:5 66:3 imminent 36:1 impression 26:11 31:19 32:4 42:9 44:2 improve 21:16 improved 18:20 21:10,11,19 improvement 37:3 37:4 inaccurate 25:20 inadequate 40:6 include 26:16 48:5 57:20 including 50:9 incomplete 54:18 increase 27:15,15 increased 18:10 20:23 29:5,23 40:15 independent 32:13 indicated 20:11 48:16,18 49:6 indirectly 65:21 individual 58:22 information 14:1 43:24 44:17,19 45:5 56:4 58:12 58:16,21 inhibitor 27:9 initial 35:11,18 48:11 injury 47:10,14,16 47:18,21 59:15,17 insomnia 40:6,7 Institute 7:11 institutions 57:8,11

57:12 instructors 33:9 45:11 46:24 47:1 62:7 63:6 insurance 59:9 intact 64:2 interested 65:20 interface 8:2 internal 6:22 7:4 internship 6:20,23 interpret 24:3 25:22 52:5 interview 15:13 involved 10:13 59:20 irritable 19:19 37:17 40:9 issue 55:22 58:1 issues 7:22 26:2 34:18 44:3 53:23 56:24	23:20 24:16,19,20 25:24 26:9 32:7,7 32:9,23 33:3 41:10 44:22 45:11 45:24 49:10 51:2 52:18 56:22,23 57:2,6 63:7 knowledge 54:24 59:14,16 known 30:2,13 Kreiner 1:11 3:3 4:2,8 10:22 13:1 15:18 48:9 K.B 2:3,6	19:4 24:5 26:4 lines 22:16 little 44:16 LLP 2:8 loans 19:8,9 long 11:21 13:17 14:8 24:21 29:19 31:23 54:8 longer 41:1 55:13 look 15:15 29:11 56:24 63:16 looked 38:1 looking 8:2 42:8 63:6 looks 15:19 38:5 loss 19:5 22:2 lot 23:4 28:17,17 32:24 54:3 low 17:15,17,19 27:11 lower 40:17 lump 16:11	35:11,15,15 36:20 38:18,21 41:7,19 43:1,18 45:16,20 45:23 46:11 47:2 47:9,24 49:1,8 55:12 57:24 60:11 60:18 61:2 62:15 Maricel's 13:5 25:7 25:16 31:20 32:21 33:6,12 39:10 40:22 44:3 51:12 55:18 mark 2:5 16:24 28:19 29:4,10 marked 13:2 15:17 match 15:17 matter 30:7 matters 65:9 mean 9:22 14:22 18:17 22:12,13,19 23:18 24:4 29:22 30:23 32:19 34:5 39:6,6 51:7,21 52:17 54:19 57:11 60:15 meaning 18:23 38:2 52:21 60:19 means 8:6,7 40:7 41:17 51:3 52:20 meant 5:13 22:5 24:16 38:15 45:8 50:19 51:19 measures 56:15,19 medical 1:6 6:17 7:8,21,24 9:2 11:7 16:10 50:9 53:19 57:2 59:6 62:20 62:21,23 medication 13:13 16:13 20:10,10 28:21 29:12,13,17 31:14 39:5,7 48:17,17,24 49:9 medications 6:8 16:15 medicine 6:22 7:4 8:3,3,15 20:13 23:23 29:4,9	31:16 49:2,7,14 meet 41:8 meeting 27:4 29:8 31:8,18,24 54:12 meetings 31:23 35:8 memory 18:11,12 26:18,20,21 mental 37:19,24 mention 22:17 24:12 47:2 mentioned 9:14 37:22 50:4 mentions 22:22 message 13:19 messages 13:24 met 9:9 middle 40:11 mind 60:5 minutes 4:17 31:23 misconduct 43:3,13 43:14 missed 24:10 missing 54:16 mold 63:5 month 30:13 months 10:21 21:5 40:22 mood 29:24 morning 28:7 36:23 move 36:15 moving 18:2 28:14 MSE 37:21 mystery 43:18 M.D 1:12 3:3 4:2
J Jackson 2:3 jeopardy 43:18 44:4 Job 54:8 59:24 jumped 17:4	L L 2:11 label 25:4 lack 35:21 lag 31:9 lapse 18:11,12 26:18,19,20 lastly 6:7 17:2 law 57:15 laws 57:8 lawsuit 10:14 57:21 leading 40:15 44:4 leave 13:19 18:4 22:6 25:9,12,14 25:14,15,17,24 26:9 35:23 36:5 38:18 41:1,2,4,6,9 41:14 54:7 leaves 54:6 led 25:15,16 left 13:23 28:12 37:14 legal 10:13 length 38:10 Let's 9:13 15:15 36:15 39:9 level 19:14 29:2 liaison 7:7,15 license 8:24 licensed 8:14 life 45:14 62:12 63:10 line 15:24 18:8,9	M main 23:21,22 majority 36:12 making 39:1 malpractice 49:7 mammograms 16:12 man 18:4 management 37:20 mania 20:3 manic 27:21 March 1:18 10:19 66:3 Marcial 1:3 2:15 9:10 11:17 52:12 52:16 53:8 54:11 54:18 55:1 59:20 64:1 Maricel 1:3 2:15 11:8 13:8,15 14:1 14:15 15:19 16:5 21:23 22:17 23:9 24:13 29:7 30:10 30:18,21 31:19 33:13,17 34:1	N N 3:1 name 15:3,21 27:3 necessarily 61:6 need 5:19,21 23:5 56:3 needed 13:13 59:11 needs 8:1 negative 37:17 negatives 27:14 never 57:23 59:8,8	

night 18:13,20,21 40:11 non-verbal 5:2 normal 19:2 38:4 normally 48:5 norms 63:3 NORTHERN 1:1 notary 1:13 note 54:14 notes 3:14 11:20,24 12:5,19 16:8,23 17:22 21:7 25:22 26:1,24 27:23 32:2 35:7,14 36:9 36:17 43:14 47:6 47:7,17 48:6,9 52:4 54:16,18 62:4 note-taking 23:14 November 10:19 49:19 50:2 51:1 number 3:12 8:11 15:20 57:4 numbers 12:6 Nurse 33:16 58:7 nursing 15:9 16:2 38:19 46:24 53:19 53:20 57:6 62:24	okay 4:16,23 5:3,4 5:14,15 6:2,6,16 8:14 9:13 10:16 10:22 11:15 15:15 16:5 17:8,24 18:2 19:10,24 24:6,10 28:8,11 29:2 35:2 37:6,6,7,7 39:9,14 39:21 40:2,5 52:1 53:7 54:20,24 64:9 once 8:21 19:11 30:2,4,8 35:3,4,7 ones 11:10 12:14 53:22 opinion 10:7 52:15 55:20 56:8,14 opportunity 52:15 57:23 optimistic 28:18 order 8:12 12:10,11 58:19 organized 12:9 OT 53:20 outcome 65:21 outside 32:14 o'clock 1:19	passing 40:17 pathology 6:24 patient 9:11 10:12 20:9 24:2 30:15 31:14 34:4 36:14 48:16 50:5 60:1 61:10 patients 7:21,24 8:12 23:4 33:19 34:9 45:7 54:22 patient's 14:23 pattern 30:8,11 peers 47:3,5 people 17:18 29:20 29:22 33:13 50:20 51:10 perceive 55:23 56:12 perceived 47:3 perception 53:1,7 61:16 62:15 perceptions 53:2 performance 18:9 26:2,18 period 52:9,14 periodically 34:16 periods 29:21 person 23:19 personal 65:13 pertinent 53:10 phone 6:3 15:20 50:13,24 physical 47:10,14 47:16,18,19,21 48:4 59:15,17 63:17 physically 60:1 physician 10:6,12 picture 44:18 pill 16:15 place 59:6 65:16 places 61:12 plaintiff 1:4 2:7 50:5 plans 36:11 Plaza 1:17 2:9 please 4:21 5:1,11 5:16 6:4,13 12:21	12:23 36:19 39:10 39:15 42:13,15 43:7 44:6,7 plus 18:23 40:13 point 5:17 30:13 39:4 55:15 points 20:20,22 21:3 23:15,21 poor 21:9 population 53:22 54:1 postgraduate 53:20 practice 8:14 9:3,4 11:16 13:8 47:21 48:5 practitioner 9:5 predisposition 27:21 prescribed 27:4 present 2:14 37:20 presentation 63:17 64:2 presently 18:3 preserved 59:13 presume 19:8 pretty 28:17,17 previous 65:6 previously 24:16 24:17 prior 13:15 probable 34:6 probably 55:12,14 problem 42:21 45:2 problems 27:18 34:18 54:3 procedure 1:16 58:10,17,18 procedures 56:21 proceed 17:24 proceedings 37:10 65:14 process 25:13 produce 11:6 professional 8:23 professors 43:23 47:1 program 6:18,19 15:8,10 16:3 22:6	24:17 31:21 32:5 32:15,22 33:13,16 38:19 41:21,22 42:10,11,19,20 43:19 44:3 45:4 45:17 47:4 55:11 55:13 56:13 58:2 58:6,7 programs 53:15,19 57:3,6 progress 39:2 provide 14:2 provided 11:2,10 59:10 providers 9:3 provost 40:17 psychiatric 7:22,23 8:1 9:23 15:13 17:9 37:24 59:7 63:21 psychiatrist 9:22 13:9 23:6 24:1 34:10 41:8 59:19 60:20 61:9 63:14 psychiatrists 7:19 psychiatrist's 59:24 psychiatry 7:1,5,7 7:17,18 8:4 52:19 psychoanalysis 7:12 8:8 psychoanalyst 7:10 8:6 psychological 59:22 psychological/ps... 53:23 psychology 7:16 psychotic 52:18,18 52:19,21,23 public 1:13 pure 29:18 49:13 pursuant 1:15 10:23 11:3 push 19:15 put 18:23 25:14 59:8 P.C 2:3 p.m 1:19
--	--	---	---	---

<p>Q</p> <p>qualified 7:10 8:6</p> <p>queasiness 28:6,9 37:18</p> <p>queasy 36:23</p> <p>question 4:22 5:11 5:24 6:4 9:24 16:24 28:19 29:4 29:10 31:7 40:14 42:12 43:10 48:8 58:15 59:18 61:19 62:17</p> <p>questions 5:10 6:10 12:15 20:17 49:15 52:3 60:10</p> <p>quit 40:1 42:6 44:15,21 46:18,22 46:23</p> <p>quotes 17:3</p>	<p>50:14 51:5,8,22 51:23 54:7 60:11</p> <p>receive 49:23</p> <p>received 49:18</p> <p>recognize 12:18</p> <p>recollection 55:5 55:17</p> <p>record 42:16 43:8 44:9 56:5 65:13</p> <p>recorded 54:14</p> <p>records 11:7,9 33:5 43:23 54:21</p> <p>redo 6:23</p> <p>redress 56:16</p> <p>reduced 65:12</p> <p>refer 11:20 12:4,14 13:12 16:7</p> <p>referral 34:14 35:12,18</p> <p>referred 33:20 34:9</p> <p>referring 13:24 21:12 43:12 50:22 50:24 51:16</p> <p>reflected 23:15</p> <p>Registered 58:7</p> <p>regular 35:2 57:3</p> <p>relate 53:9</p> <p>relative 65:17,18</p> <p>relatively 17:15</p> <p>released 58:21</p> <p>relief 59:23</p> <p>remember 13:17 14:5,21 22:21 26:10 32:19 33:2 53:21</p> <p>remind 50:15</p> <p>reminding 51:4</p> <p>repeat 42:12 43:5,6 44:6 55:24 56:3</p> <p>rephrase 54:4</p> <p>report 11:22 60:20 60:21,23</p> <p>reported 16:11 18:4 26:6 29:14 44:19 47:13 53:11 59:22 60:11,16,22 60:23 61:5,7,14 62:16 65:11</p>	<p>reporter 5:6 56:2 65:4</p> <p>reporting 46:2,12 61:3</p> <p>reports 46:14 47:21</p> <p>represented 50:8</p> <p>reprimands 8:23</p> <p>reputation 33:12</p> <p>requested 11:7 49:5</p> <p>require 62:24</p> <p>required 7:3 10:15</p> <p>requirements 8:12</p> <p>requires 62:24</p> <p>residency 6:22 7:5 57:2,3</p> <p>resident 7:1</p> <p>residents 57:5</p> <p>respect 51:12</p> <p>respond 6:10</p> <p>response 17:19 60:9</p> <p>responses 5:2,3</p> <p>result 10:13</p> <p>retain 19:10</p> <p>reuptake 27:9</p> <p>reveal 45:4 58:16</p> <p>review 4:16 33:5</p> <p>re-certified 8:21</p> <p>right 5:16 9:16 10:24 12:9,11 17:22 21:1 28:4 38:8 49:20,24 50:6,10 52:12 55:16,20 56:19,21 56:23 57:9,14 58:8 59:18</p> <p>risk 27:11 42:1 43:2</p> <p>risks 20:12 27:7</p> <p>Riverside 1:17 2:9</p> <p>rule 4:20</p> <p>rules 1:15 4:18</p> <p>running 19:12</p> <p>Rush 1:6 7:2 13:10 25:10 31:21 32:5 32:24 33:6,9 34:10 40:24 41:2</p>	<p>41:3 50:9 53:18 53:22 55:13 58:1 58:8 59:2,5,10 61:17 62:20</p> <p>S</p> <p>S 3:11</p> <p>sad 19:11</p> <p>sadness 38:3</p> <p>SAITH 64:14</p> <p>saw 27:24 52:24 53:18</p> <p>saying 51:5,18,23 60:18</p> <p>says 18:8,9 37:4 39:16 61:10</p> <p>schizophrenia 16:22</p> <p>school 19:21 23:2,9 23:14 24:14 25:10 28:14,15 40:14,15 42:1 43:2,3 53:19 53:19,20 62:20,23 62:24</p> <p>schooling 24:18</p> <p>schools 62:21</p> <p>screening 20:1</p> <p>seal 66:2</p> <p>second 31:10,11</p> <p>secondary 26:22 40:3,12</p> <p>secondhand 33:12</p> <p>section 53:22</p> <p>see 7:20 15:2,7 21:6 21:10,19 23:5 26:4,23 27:2 31:14 41:6,12,12 49:23 53:21 54:5 54:11 57:4</p> <p>seeing 15:7</p> <p>seen 13:11 17:10,20 25:10 45:3 47:18 59:12 63:12</p> <p>seizures 20:3</p> <p>selective 27:9</p> <p>self 19:15 64:3</p> <p>self-presentation 63:20</p>	<p>sense 21:2 39:20</p> <p>separate 31:4</p> <p>September 29:8,8 31:8,12,18</p> <p>serious 35:24</p> <p>serotonin 27:9</p> <p>service 59:10</p> <p>serving 34:10</p> <p>sessions 54:21</p> <p>set 12:20 49:15 66:1</p> <p>setting 59:3</p> <p>seven 18:21</p> <p>seven-year 6:18</p> <p>sexual 27:18</p> <p>shared 20:17</p> <p>sheet 15:2</p> <p>short 29:21 37:10</p> <p>Shorthand 65:4</p> <p>show 63:21</p> <p>side 28:3 36:21</p> <p>SIEGEL 2:3,6 3:5 3:7 12:20 22:7 35:20 43:9 52:2,8 56:7 60:3 61:19 62:2 64:5</p> <p>Siegeledlaw@aol... 2:5</p> <p>Siegel's 60:9</p> <p>sign 64:8</p> <p>signature 64:11</p> <p>significance 47:22</p> <p>signs 63:21</p> <p>similar 10:14</p> <p>simple 18:11</p> <p>sit 43:17 51:9</p> <p>situation 25:1 37:2 38:14 61:16</p> <p>six 10:21</p> <p>six-year 6:18</p> <p>skin 17:13</p> <p>sleep 27:18 40:2,6,8</p> <p>sleeping 18:19 21:8 21:13 28:24 29:15 37:6</p> <p>smoked 16:18</p> <p>snippets 43:24</p> <p>solo 9:5</p>
<p>R</p> <p>R 65:1,1,1,1</p> <p>raised 23:17</p> <p>range 37:20 38:2</p> <p>rational 55:21 57:16</p> <p>rattled 37:1 38:13</p> <p>reaction 31:4</p> <p>read 16:1,23 17:4,7 17:22 18:6,12 19:22 28:19 37:16 40:3,12 42:14,16 43:8 44:7,9 56:5 62:4 64:7</p> <p>reads 19:4</p> <p>real 17:1</p> <p>reality 52:16,20</p> <p>really 17:12 18:24 18:24 47:16 51:21</p> <p>reams 23:20,20</p> <p>reason 12:17 25:24 26:8 42:6 51:10 54:17</p> <p>reasons 44:12</p> <p>recall 14:15 30:21 33:14,24 34:2,7 35:10,13 36:2 41:11,15 42:24</p>				

somebody 30:2 47:21 49:7 soon 6:4 sorry 7:18 19:23 37:9 48:15 50:16 53:4 sort 5:2 36:9 47:14 sought 13:8 59:23 sound 51:15 source 55:1 South 1:17 2:9 6:17 speak 33:8 43:23 56:11,11 57:24 speaking 34:5 35:10 specific 34:24 specifically 13:20 21:12 26:16 45:7 45:20 57:6 specified 65:16 speculate 12:1 26:8 speculating 14:20 22:8 23:7 30:17 32:2 36:4 49:12 speculation 22:7 25:23 29:19 45:1 45:2 49:13 55:8 spoke 36:2 50:12 staff 9:6 stage 24:18 stand 51:17 start 6:13 15:12 starting 6:14 31:13 31:15 state 1:14 8:15 30:20 63:22 65:5 states 1:1,16 8:17 status 37:19,24 stay 7:23 59:7 stayed 7:6 stenographically 65:11 step 5:21 stick 11:23 14:18 25:18 30:17 32:1 32:17 62:22 stomach 27:17 37:4 stop 14:6,13	stress 26:13 28:12 40:3,16 stressful 25:11,14 stressor 25:3,7 26:3 26:21 31:6 stressors 26:3 stretching 52:10 Strike 46:20 student 19:9 34:14 34:15,19,20 53:22 53:24 55:21 57:14 57:16 58:6,7 62:20 63:7,8,9 students 13:20,24 14:4,7,8 15:5 25:10 32:24 33:20 34:10,24 35:1,6 35:16,18 36:9 40:24 45:3 53:13 53:14,18 54:2,4,5 54:10 55:11 56:12 57:1 58:6,13,22 59:4,12 62:19 63:5,12 students/patients 13:12 stuff 19:5 subjective 61:3 subjectively 46:2,3 subpoena 10:23 11:3 49:18 50:6 subset 53:24 54:1 substantially 41:20 suffered 30:16 suggested 64:1 suggestions 41:12 suicidal 19:19 27:16 29:3 34:21 37:17 40:10 suicidality 35:24 suicide 17:5 Suite 1:17 2:3,9 supervised 8:11 sure 4:19 9:23 11:22 12:8,10,12 17:4,6 20:10,19 21:18 22:3,4 30:24 36:20 46:5	48:10,17 49:17 50:22 51:2 56:1,2 59:14 60:6,14 62:5 Surely 58:24 surgery 8:3 surgical 7:21,24 suspensions 8:24 switched 7:1 sworn 4:1,4 65:8 symptoms 23:22 30:14 37:5 49:14 59:22 system 39:24 40:19 42:5,21 44:14,20 44:21,24 45:9 46:7,10,12,13,17 55:14 60:16 61:15 62:18 systems 59:21 <hr/> T T 3:11 65:1,1,1 take 5:7,17,24 6:5 15:1,2 22:12 37:9 49:1,8 55:21 56:15,19,24 57:17 taken 1:12,15 4:11 17:14 29:6 65:15 talk 23:8 41:22 talked 41:19 talking 45:18 47:15 63:11 tears 28:23 tell 16:6 21:6 36:18 39:4 41:24 55:10 ten 14:9 54:8 tension 19:13 Terebessy 13:11,12 13:14,23 15:21 33:21,22 34:3,8 34:13 35:8,11,17 36:3,8 55:10 Teresa 1:13 5:5 65:3 66:8 term 52:20 terminated 56:13 56:18 58:3	termination 55:18 58:1 terms 24:20 29:14 57:17 64:2 terrified 18:14 testified 4:4 58:5 59:14 60:10 62:3 testify 58:20 65:8 testimony 10:15,17 65:14 tests 8:10 thank 6:12 7:13,18 11:15 16:5 20:14 46:19 52:3,3 60:2 61:18 Thanks 4:10 theft 43:3,12 therapist 23:24 therapy 48:22,23 thing 5:22 25:11 35:24 36:1 59:2 61:9 things 5:6 18:12 22:11 30:6,20 36:10 41:18 61:14 63:13,16 think 9:17,18,18 12:5 19:4 25:21 28:15 37:3,5 38:18 45:10 48:15 51:9,13 54:15 thirdhand 33:11 thought 32:6 49:6 thoughts 27:17 29:3 40:10 three 7:3,4 31:15 31:17 thyroid 20:5 tied 18:8 time 10:9 11:21 13:9,17 14:9 20:22 21:3,10 24:20 25:7,8 26:14 27:24 28:10 29:19 31:9 33:16 38:10 50:4 52:10 52:14,24 53:14,14 65:16	times 4:14 10:11 23:16 36:12 40:5 today 4:10,18 6:10 43:17 51:9,17 told 13:14 16:23 24:13 29:7 32:14 32:22 44:10 61:14 61:14 tolerate 37:18 top 26:13 total 25:23 45:1 totally 33:1 59:6 touch 33:15 34:16 34:17,22,23 52:16 55:9 touched 35:17 Town 6:17 trained 6:16 7:10 transcript 64:8 65:11 treat 7:23 11:16 27:10 treated 32:23 40:18 57:1,5 62:19 treating 10:5,12 23:24 27:12 33:17 33:19 34:4,15 36:10 41:1 43:20 treatment 36:11 38:21 59:7 trigger 29:24 triggers 30:5,9 trip 37:8 true 46:9 61:6 65:13 truth 65:8 try 20:11 23:21 54:20,23 trying 23:12 30:19 30:22 52:5 62:3 turn 12:16 20:16 27:22 Turning 27:2 twice 35:4,8 twitch 28:4 twitching 36:22 two 6:24 18:6 19:22 20:22 26:7 31:15
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U undergo 8:9 undergraduate 6:15 understand 5:11,13 6:10 9:23 22:18 23:12,13 24:11 30:19 34:8 58:14 60:15 understanding 32:14 Understood 5:22 6:5 10:1,16 unfair 56:10 Unfortunately 28:18 United 1:1,16 university 1:6 13:10 50:9 55:6 56:20 unjust 55:23 56:10 unusual 41:5 update 33:22 updates 34:3 upset 27:17 urgent 36:1 urgently 34:22 use 12:6 16:19 usual 19:20 usually 14:2,23 15:1 31:13,14 33:21	W wait 4:21 Waiting 40:16 waive 64:10 wake 18:13,14 wakes 40:11 walk 6:14 16:8 27:23 39:14 walking 20:14 52:4 wander 11:24 wane 29:20 want 4:18 11:22 17:6 25:18,19 30:12,17 32:17 39:24 46:17,22 49:8 55:24 58:14 60:14 64:10 wanted 4:17 20:9 42:5 44:14 46:23 49:1 wanting 44:21 wants 48:16 wasn't 16:14,14,15 20:10 29:13 38:19 41:13 42:20 49:3 51:16 wax 29:20 way 12:9 30:2 49:4 51:17 63:1,1,2 weeks 31:15,17 38:6 49:22 weigh 10:6 weight 27:13 went 6:21 11:8 37:7 37:8 47:6 weren't 10:4 31:23 55:11 West 2:3 WHEREOF 66:1	X X 3:1,11 Y yeah 17:17 25:5 26:6 51:2 year 6:19,22 7:4,6 35:3,4,8 yearly 16:12 years 6:24 7:3,4,11 8:7 14:9 30:16		
V various 8:8,10,11 verbal 5:3 version 12:6 vice 40:16 view 38:20 violated 57:15 visible 28:4				

EXHIBIT

A21

8/15/13

Manuel Marcia
2616 N. Spading #3
Chicago, IL 60647
(847) 809-5669

D.O.B. 1/21/1913

Emmy Cantat: Joint Affidavit (713) 531-909
(b)(7)(C)

Dr. Tereshchenko

Nancy Ann

Marcel Marcial

8/15/13 Medical Hx:

Brent up - yep marcial

Melicet

⊖ oc.

⊖ Melicet

Au: NADA

Soc: Snae ⊖

ETOM - oc.

⊖ Dmg.

FHx: ⊖ Depress Ant/cons ? initial anix

⊖ BPD ⊖ Schiz

Briv - "order" - "jupet" - scumid

Pat 4 Hx:

Saw on autre cas de -

to do lde of 2000ft — my anix -

sluicing out of me . (25y 1x day)

8/15/13

About to be on a line of chance

Had a man in a car and got to write up.

→ 2 bad ends. → copy

Thru the north paper.

Among 4 of right side legs of many

Wake up tonight of all the go to expect me.

Among 44 → any is has you don

Step 4-52/a → upwordline (7h/mt)

Used to force up to cut ④ → again be out here to (N)

Could keep any down.

But in USA → avoid about any place.

Also feel about don't it.

Wad don't if I don't go to public (also have lines).

Four - one. - can not be one.

One is a white fed and red and any.

Ben my d day Yarn - to d tennis

Every best - for (see don't he to do not all
dys can put it it)

Sony today me too for any my web (if what's for or
about, hundred of
what is going on)

⑤ SI.

More with the word.

In the past so even of days

But he any is school before - when don't feel good again.

- o lvs of am / melon
- o lvs of man / banana
- o scapula 1st HA.
- lvs of ch ✓
- o lvs of ocd.

Mr. Amis the 2 Amis

→ say later.

Pt wa to be on melon

I'm not out if melon is indicated.

Try lvs log (x 12-15 d)

[Signature]

9/6/13 lvs log (x 18-15 d)

scapula is 1st eye - not visible but feel it

→ greenish in the HA ⊙ (also to eat - quite is ok)

→ not bottom - feel one of the two

⊕ Skewy hys

held back of at

hys at to hys
school.

Held back for school → which is wrong

A lot of pny pld dpy - more yptanion but do pny me nrt

Try D f the melon ypt

Ab way up there

Slung 8th into - (8th)

Applite - her arm.

Fame - she

Engled - her good @

② ST

A/1

≡ Try & 4/6/16 to 2011 she 2/1/17

12

Mania Minsky

10/12/13

Celebr 20y post .

B.e. I think you are
but still you remember in the AM .

Not very depressed

↓ anxiety - don't feel as rattled but not in the
situation . Important is that my life is also .

Sleepy - OK ; Appetite - OK -

Energy - OK . Focus, OK .

Had some fun - went on a trip - went diving .

Admiring it - set aside about by don't know .

Trachea ☹ .

☹ SE

Can tolerate the pressure

MSE : A new, just range .

App CPUs .

Key

Manuel Mancera

2/12/14

Celeste 2008 post

⊕ grey hole to school; ? who will
get kicked out of school → 40 years.
Way to her for the Der + Uni Point.
hope as low of party or going to the Party
feel that not big to Fairy
Feels like there's a point; feel not big bullies

→ Don't feel that it's key of any →

it's what I'm up against -

grey just the body system -
they want you to point.

able to sleep, quite - Oh but as like
how 3° to sleep

Every - Oh, for - at this time

sleep is a little bit more

but don't put on sleep

of Intuition.

Anchoring ⊕ (for hot to jump
of Intuition)

⊕ SI One with guide in of not even 20 to 6

AN UP the; Celeste 2008 post
Xams 02.5, 1, per for enter already

EXHIBIT

A22

Maricel Marcial

847/809-5669

6/5/21

7/24/13 (initial appointment): same day appointment for this Nursing Anesthesia student who had scheduled an appointment for 7/17 and then cancelled it at the time she was supposed to come due to her clinical schedule. This woman is in the residency portion of the program, and is in danger of dismissal due to several poor evaluations that she has received from CRNAs ("Jill" and "Eva") who appear to be close friends. She believes that J. has influenced E. to write a negative evaluation. This woman has worked in telemetry and the ICU at Lutheran General since emigrating to the U.S. from the Philippines, where she went to nursing school. She came with her parents and siblings. She started the didactic portion of the program in 2011, and chose to attend Rush precisely because it has a reputation for rigor. She wants to be challenged, and wants to be able to say that she is a Rush-trained nurse. She has a 3.6 GPA, and has received a number of solid, positive evaluations, along with the two negative ones; a third eval has one negative rating (among 5). She has met with the program director and the assistant director and has been told that she has three weeks to collect 13 positive evaluations, or else she will be dismissed from the program. She said several times that she is "fighting for [her] life", and wonders every day if this will be the last day in the program. She became tearful when she talked about how her parents would react if she were dismissed - she knows that they are very proud of her and are counting on her to succeed in this program.

"Yosh"

This woman lives with her boyfriend who graduated from medical school but who teaches, rather than practices clinical medicine. He has been very supportive, and has said that if she is dismissed, they should hire a lawyer and sue Rush. I said that I did not expect that they would prevail by taking this approach. She has received a lot of support from a senior student who has survived being on probation twice, and who encouraged her to come to the Counseling Center. Several other classmates have also voiced their support of her, and have said that in their estimation, she is performing at an acceptable level. A number of them said that they, too, have had very negative experiences with one of the CRNAs who has given M. a rough time (J.).

In the absence of a university ombudsperson, I suggested that she speak with either Dr. Lois Halstead or Dr. Melanie Dreher about her situation, and her desire to succeed in the program. She needs to feel supported, and to have her faculty help her to be successful, rather than threaten her with dismissal. I encouraged her to focus on success in the OR, not on the shame of dismissal. I further suggested that she do a better job of clarifying expectations and instructions since it appears that many of her difficulties stem from a failure to do this. She is aware of my continuing availability.

8/2/13 (#2): met with program heads yesterday following another negative evaluation. One suggested LOT which I supported. Reviewed sleep hygiene principles and discussed importance of exercise for stress management. Encouraged her to pursue yoga on a week-end day along with her usual running. Referred her to K. K. K. or med 212, although

Marci

P. 2

Said I think psychiatrist is out of the office for vacation until 8/12. Said combination of addressing sleep debt, exercise, med. and regular psychotherapy, to help her regain confidence and sense of self-worth, plus shadowing CRNA and a lot of studying to shore up knowledge base, will likely make a difference for her. She had scheduled an appt with Litalstad, but decided to cancel it when it became evident that her program is willing to work with her. Will call for next appt once details of LOA are spelled out.

8/8/13 (#3): took LOA which will last ~ 3 1/2 mo. This is in stead of failing current rotation and being dismissed. She feels ashamed that she wasn't successful, embarrassed to tell people what happened, but has plans to study and learn as much as she can while she is away from OR. Told her her tendency to explain too much, to defend her decisions or actions when she has been corrected, rather than accept the correction and

Marial

p. 3

agree to doing it in the specified manner the next time. She acknowledged that she does this, sees how it can be a problem. Encouraged her to try to get in to see K Kriener next week before I'm officially notified of her LOA. then see her as a self-paying patient until she re-enrolls in 12/13(?). Encouraged her to continue to exercise for its mood regulation benefit. F.u. on 8/13/13.

8/13/13 (#4): has appt with K Kriener on 8/16. Discussed fact that she is still mentally fighting fact that she failed initiation so has to take LOA. fighting fact that program seems to pick on one victim in each cohort, etc. Urged her to accept this outcome and work on fixing problem that led up to it. Specifically, talked with her re: tendency to challenge authority of people over her but appearing to question them, or explaining her reasons for

Marcial

P. 4

handling things the way she did. This defensiveness is seen as a challenge to their authority, so she has to get much better at simply accepting their corrections and making behavior changes accordingly. Said she already feels more relaxed than she did while working in the OR. Has been running more often and plans to sign up for a half-marathon, which she has done in the past. Also contacted choir director at her church and wants to pursue this creative outlet as means of managing her stress. She and J. plan to take a couple of vacations, including to Germany to visit his brother. Talked to: viewing LOT as speeding ticket; others have also "exceeded the speed limit" but she got singled out. She can't argue with the judge - she just has to pay the fine and be more attentive to posted signs moving forward, etc. F.W. Scheduled on 8/20/13.

8/20/13 (TS): saw KKreiner on 8/16 and was prescribed Celebra.

Marciel
P.5

So far is tolerating a low dose of the medication. Heard from her, as well as from more senior students in the program, that it is important to be seen as teachable, cooperative, willing to fix mistakes. Reiterated that she shouldn't appear to question or resist instructors, and she needs to be calmer, better able to adapt to what is going on in OR. I talked w/ her the need to shift her focus away from information mastered to the process of working fluidly in OR. Encouraged her to study ~2 hrs per day along with running, yoga, singing in church choir, and hanging out with friends. Focus should be on how to better manage stress, not on cramming her head with facts. Has f.u. with psychiatrist on 8/30, and since LOT hasn't started yet, will come to see me on 8/27.

8/20/13: informed that she took LOT on this date. Will keep previously scheduled appt with me and with KR.

8/27/13 (#6): final appt until she returns to program 9/1/14.

Marial

p. 6

Feeling some side effects of medication which I encouraged her to discuss with psychiatrist when they meet on 8/30. Said she is feeling better, but we can't say whether it is due to medication, fact that she isn't in OR, she is exercising more, or some interaction of all of these things. Discussed again the shift that has to take place in order for her to succeed in the OR: she can't question CRNAs or appear to resist what she is told to do/not do -- she has to agree to what is being asked of her. Should correct the record if something patently false is said about her, but otherwise she should accept the correction and indicate that she'll do it differently next time. Talked re: "sucking it up," not being defensive. Knows she can contact me via e-mail during her LOA, and I indicated a willingness to refer her out to someone in private practice if she prefers.

9/13/13 (#7): Saw M. at request of K Krecher who inquired

Marcial

p. 7

M.'s medication and wanted her to have additional contact during adjustment period. M. seems to be doing fine. More relaxed, better rested, is exercising more. Shadowed anesthesiologist at Littleton General and got good feedback on her case management and her OR skills. Knows that when she feels supported she does fine. Talked re: what she needs to do to be successful in 1/14 including: not resisting instruction or correction by CRNAs; not being defensive; and being more confident. Asked her to think re: model of inoculations, her now-increased ability to withstand "infection" in OR because of "vaccine" she received this summer, etc.

10/29/13 (28): phone consultation. Had been doing very well, was more confident re: her return to program in 1/14.

Marcial

p. 8

Met with program director (McKremer) who voiced support for her actions during her LOA and who seemed to be encouraging her return to program. Together they met with Ray Narbone who was nothing short of hostile toward her. He told her she was unfit and unwanted by CPMA and he predicted that she would fail if she returned. He actually bullied her and suggested that she was too old to succeed! I told her to schedule an appt with Litalstead to discuss what happened. I further suggested that she prepare a bullet pointed sheet (2 pgs) summarizing the events leading up to this point. I offered to review it prior to her meeting.

4/1/13: told KKremer by phone that M. is on LOA and must be self-paying patient until 4/14.

4/4/13: phone consultation with Dr. who wanted guidance re: what kinds of information to include in her document that she plans to bring to her 4/14 meeting with Litalstead.

Marcia

P. 9

12/30/13 (#9): discussed her return to the program on 1/6, probationary status, possibility that this career path might not be an option. Talked w: inoculating her against negative evaluations and judgments, importance of not being defensive and learning to accept their efforts to teach her, etc. Reminded her that doing so will not strip her of her dignity or integrity, etc. Will contact me when she learns her new schedule.

1/20/14: returned M.'s phone call. She wanted to discuss negative experience she had with CRNA ("Jill") on Monday. Encouraged her to come in to discuss situation in person. Sent her e-mail with open time slots.

1/27/14: called at her request. Is in TN at L³ grandmother's hospital bedside, where they are about to be married. Met with program director on 1/24 and is convinced that faculty has no intention of allowing her to graduate, they are railroadng her out of the program. Plans to meet with L Halstead to discuss this

Marcial

P. 10

1/30/14: last minute cancellation - in TN to attend husband's grandmother's funeral. Re-sched for 2/5.

2/4/14: brief phone consult to discuss her upcoming meeting with Littlestead. Feels program is actively trying to exclude her, isn't fair in their evaluations of her or performance.

2/5/14: last minute cancellation due to OR schedule. Re-sched for 2/6/14.

2/6/14 (#9): ~20 min late. Met with M. and G. to whom she is now married to discuss strategy for meeting with Mark Foreman, Ph.D., Acting Dean of CON. This meeting was suggested by Littlestead on 2/4.

3/14/14: last minute cancellation

3/18/14 (#10): she is convinced that in 5 weeks she will be failed on her current rotation resulting in dismissal from the program. They both feel that Littlestead and M Foreman have washed their hands of this situation, and are not resources to help. They asked a lot of questions re: Sinking Rush. I

Marcial

P.11

repeatedly said that I cannot advise them in this matter, but I believe that it would be "ugly," that it would be portrayed in a negative light, and it is unlikely that she would win. She asked how she can get through the next 5 weeks knowing that she will be dismissed. I talked to her pride and integrity, ability to look back at her work and feel very positive to her efforts on behalf of patients, etc. Encouraged her to work hard and perform to the best of her ability, etc.

4/23/14: no show

4/29/14 (Sat): phone session. this detached lawyer (- R. Rosenberg) who has been in communication with Rush / O'Rice. Because of this, program director has asked her to not come to school until matter is resolved. She would like to be allowed to work in an OR anywhere but at Rush because she feels that CRNAs here have been "prisoned" and everyone holds negative bias. Doesn't feel that she'd

Marx

p. 12

to be given fair chance to succeed. Wants level playing field which she feels she doesn't have here. Was advised to meet with HR staff member who handles discrimination (Sharon Shumpert). Was made to feel that attorney (SS) wants her to just leave and stop fighting this battle -- did not feel supported or encouraged. Expects decision to be made in next few days, and may/may not be at work on 5/5. Will keep me posted.

(phone session)
6/5/14 (2012): Was allowed to return to work and led to believe that she would be given 5 wks to demonstrate competency. Was sent home and told to either withdraw from the program or she would be failed. She declined to withdraw so was failed. When her atty brought this development (and the conditions leading up to it) to attention of David Rice, he expressed surprise since the conditions agreed upon by Rush weren't honored. A.

Marcial

P13

Continues to feel that she is being set up to fail, that there is a campaign to get rid of her. She intends to file charges with the ECC to effect that she is being treated in a discriminatory manner. At least 2 students have also filed a complaint, and 2 others say they plan to do so. She was on a break from work at LGH and had to return to duties. Said she would keep me posted.

9/19/14: informed hi. has taken a lot.



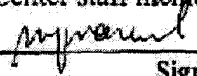
RUSH UNIVERSITY
MEDICAL CENTER

COUNSELING CENTER

INFORMATION SHEET

Name: MARCEL Q. MARCIL
Address: 2616 N. SPAULDING AVE APT. #3
City/Zip: CHICAGO, 60647
Home Phone: 847-809-5669 Other Phone: 847-209-9862
Date of Birth: 1/21/73
Email Address: MILESOMIE@HOTMAIL.COM

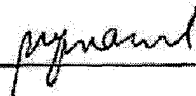
I hereby authorize Counseling Center staff members to contact me using the above

E-mail address: 
Signature

Emergency Contact Information:

Name: JOSEF MENDELSON
Relation to you: BOYFRIEND
Phone Number: 773 531-1909

YOUR SIGNATURE HERE INDICATES THAT YOU HAVE READ THE
PSYCHOTHERAPIST - CLIENT AGREEMENT AND AGREE TO ITS TERMS.

Signature:  Date: 7/24/13

Hilarie C Terebessy

From: maricel marcial [milesonne@hotmail.com]
Sent: Monday, October 28, 2013 1:37 AM
To: Hilarie C Terebessy
Subject: My meeting with Dr Kremer and Ray Narbone

Dear Dr. Terebessy,

How are you?

I wanted to write you to tell you about a pretty bad experience I had last week. I wanted to write you at the time, but after the meeting I really wasn't able to think clearly. However, I wanted to let you know about what happened as you have so supportive throughout this whole ordeal at Rush and I am hoping you might be able to give me some advice in terms of how I can complete the program.

On Thursday I went in for a check-in visit with Dr. Kremer. I was feeling pretty good about things as I have been working extremely hard studying (and I'm not exaggerating) between 5-6 hours almost every single day when I am not working. I only work 2-3 days a week. I have also been shadowing an anesthesiologist at Lutheran and another one who has been extremely supportive in Rockford. I have also been making sure that I exercise most days.

All in all, I was happy that I was managing to push myself in spite of all the misery of my initial experience during that second month of clinicals at Rush. I felt that even though I knew that the return to school in January would be stressful, I would manage and would be successful.

Then on Thursday morning I went to meet with Dr. Kremer. The meeting seemed to be going fine until he said that we should meet with Ray Narbone who oversees the CRNAs to discuss the plans for my return. I was quite happy to hear this as I felt that at last there was a true sense of support coming from the administration.

At that point everything fell apart.

It was miserable. Ray berated me throughout the entire meeting. He told me that I was delusional (that's the term he used). He said that I was in denial if I thought I had any chance of getting through the program. He said things that reminded me of a mean clique in high school. For example, he repeated to me that when he mentioned to a CRNA I was coming back in January, she said "God, I hope not". I find it hard to believe that any CRNA who oversees students would say that unprompted. At the very least, I would want to know exactly what prompted that kind of comment.

Ray had a great deal more to say – some of which completely amazed and devastated me. I had been warned by two female students that there were issues with Ray where he could be a real bully especially if he felt that he was being challenged. I just never expected it to manifest so intensely.

He also told me that he would be unable to control the CRNAs as they would all be questioning my return and that they almost unanimously felt that I did not belong there. (I know for a fact that this is not true as several of them were very positive about my performance when I was with them). Ray further said that he could not control the attitude of the CRNA preceptors towards me upon my return as it is "human nature" and there is nothing he can do to mitigate their behavior towards me.

I was speechless that the manager of the CRNAs tells me that he neither intends nor wishes to tell his own staff to support me or at least give me the benefit of the doubt upon my return. It just reinforced my belief that they are setting me up to fail.

To make things even worse, during all of this, Dr. Kremer, who would always act supportive in private and on a few occasions told me that he was going to support me "every step of the way" did nothing but nod in agreement with everything Ray said and even reinforced it. I just felt so ganged up on, I was dumbfounded.

Dr. Terebessy, this already too-long email is actually not the first version I wrote you. In fact, I initially wrote you a much longer one as I have been keeping track of things and that version summarized many of them. However as a result, it turned out to be quite long. I realized that to send something like that to you was probably an imposition and possibly even disrespectful of your time. You have been so supportive that I did not want to take advantage of you in that way. I would, of course, be happy to show it to you if you would like to see it.

But I felt like I had to tell you about this latest experience. I can't help but feel that I am being railroaded out of this program.

I have put so much work, time, and emotional energy into this. I feel like I am being bullied every which way. It is such an injustice and is causing me so much pain. I KNOW that I can do this. I am a very capable nurse with 12 years of ICU experience and a very good reputation at Lutheran. I am also a hard worker. Why is it that the very people who I would have hoped would have supported me are the ones who are so determined to make sure that I fail?

I am at a complete loss. I hope you can help.

Thank you so much as always.
Marice!

October 2013:

It turns out that Ray and others wanted me to take my leave with the idea that it was only there only for me to decide to quit. This is very different from the approach that was as it was suggested to me. It is also, I believe, very different from the approach that a leave is intended for to any student. Mary Johnson suggested that I should take that leave. Personally, I only wanted a one month leave per Dr Terebessy but Mary clarified that it would not be possible because of academic scheduling and that I need to be assigned a grade. She said that from her experience with nursing students she dealt with in the past were advised to take time off to re group and that would help them come back refreshed and calibrated. That was the reassurance they gave me in addition to the possibility of reversing the withdrawal/non pass grade that I had to accept in line with the unsatisfactory evals that I've received so far.

It seems clear that the decision to allow me to take the leave was made in bad-faith – at least from the people in whose hands my future now rests.

OTHER NOTES from OCTOBER 24:

*Met with MK and we discussed what I have been doing during LOA. He jotted down in his notepad the activities I've been involved with which included reviewing Prodigy review, Valley review course, some anesthesia books and exercising and watching my diet.

* Mentioned to him that I've been shadowing anesthesiologist at Lutheran and that he's allowed me to run cases with minimal supervision from start to finish. I added that my CRNA friend will also help me out with shadowing in Rockford and that he's been helpful with providing practical tips in clinical residency. (MK approved of this plan before my LOA)

*He verbalized being pleased with how I've spent this time of leave and noted that I've undertaken some healthy stress management skills that will help me in my return back in January. He was somewhat apologetic about the incidents I've had with Jill and Eva and conceded that in the OR there are plenty of personalities which can be difficult or challenging but reassured me that he will inform Ray to limit my interaction with them in clinicals.

* I had asked how the juniors were doing with their clinicals as they had just started and he said they seem to be doing fine but they were apparently forewarned by the seniors that there is some "hazing" that goes on during clinicals; MK seemed incredulous that the juniors were being scared by this impression, he feels that there are challenging personalities but such a thing as hazing seemed far-fetched and probably a rare if even an occurrence at all during residency training.

*We again revisited the terms for the LOA and said that in the first month of my return I will be assigned to a CRNA (I was a little surprised as I thought that since I was still on probation that I would still need a full 3 months of CRNA supervision). He then advised, "just make sure you review you're "drugs to know by heart" real well and if there's a question you couldn't answer then respond by saying I don't know it right now but I will look it up later and get back to you on it". He said I'm sure Ray will try to ease you

into it by starting you with simple, not so-challenging cases at the beginning and so I just need to know the basics (got the impression that he was reassuring me that I don't need to be at the level I was in before LOA when I come back). "Nonetheless, cases change easily and so be prepared and flexible to take whatever he assigns you to do. "

*As far as evaluations he repeated that if unsatisfactory evals start coming again that I will get a verbal warning at first then 2nd time around a written warning and if things don't go well then we can talk about transitioning me to CNL (clinical nurse leader) program so I can get full credits for all the courses I've taken before. I agreed to all of the aforementioned conditions. He then said, " I give you my word, Maricel that when you return I will support you in being successful with your overall clinical experience."

*He then mentioned trying to set-up a time to do lab skills days on Mondays a month prior to my return so I can be refreshed with the basic skills such as induction, intubations and emergence anesthesia. And this will be done with either Keith or MK. I gave him 3 days (he asked for 2 days initially) and scheduled it right there and then in the month of December. Afterwards he said that it would be better if we met with Ray today to discuss the plans for my return. He got on the phone and per their conversation, Ray wanted to meet us at his office in the Jelke building (MK planned to meet him in the OR initially).

ALL THIS WAS GREAT - AND I WAS GETTING HAPPIER AND HAPPIER IN THE BELIEF THAT Dr. KREMER WAS INDEED WANTING TO BE SUPPORTIVE AND SEE ME SUCCEED AFTER ALL.

*We arrived at Ray's office where he was awaiting us and upon seating he asked me how I've been doing. I said I've been feeling good with having recovered and rested well during my leave and that I've been studying and shadowing (same thing I told MK). He then asked me, "Why do you want to be in nurse anesthesia?" I told him my reasons specifically my passion for critical care and I found it very fulfilling and gratifying to be doing this work and this is where I see my career going. He then looked irritated and started berating me saying, " You see I don't think that you are a 'fit' at all for the program, you are really 'pushing the envelope' . It's like you're a square peg in a round hole, it just does not work and you can't force it."

I got the sense that Ray had suddenly gotten extremely irritated when he realized that I wasn't planning on just 'going away'.

* Ray says: "I thought that when you left, you would be coming back in a few weeks to tell us that you going to drop out of the program and so I am surprised to hear that you were still around."

Ray says that shadowing - at least the type that *I* am trying to do is pointless.

"I don't think this plan of yours to be shadowing anesthesiologists and CRNAs outside Rush is gonna work because the critical care decisions is theirs not yours so it won't help you and I don't know who's idea this was because it isn't going to help you. Plus the acuity of cases and standards in those hospitals is not the same as the standards here at Rush.

This last comment was revealing as Ray had no idea of which hospitals I was talking about. He never had asked and I had never mentioned it. I think it is just another thing that shows that he was determined to simply bully me and

ensure that whatever I did, his intent is ONLY to make sure that this doesn't work out for me.

Ray continues the theme of how I am an absolutley awful fit - and that I have no real business even trying.

"You need to open your eyes and realize this is not a fit for you. Even if you try to apply in other places for nurse anesthesia it would be difficult or even impossible because they would have to talk to us and we would have to tell them about your poor performance. It's not enough that you wish this, THINK. Don't let your mind, your heart or your emotions make this decision because you are just not a fit for this program. There are people who are not meant to do this so don't force the issue. As an example there was a child in the OR who was scheduled for a myringotomy and ended up having an arrest. Can you imagine taking care of that or being in that situation?. I replied it certainly sounds overwhelming - and he cuts me off and says "You can't be overwhelmed! You need to be able to act promptly during these stressful situations. Now can you imagine being in charge of this child's life?"

Ray declares that I am also emotionally unfit. (How in the world did he decide that he could know and state that???)

He then said, "You just don't have the emotional readiness to deal with this kind of things. You have the smarts but you don't have the emotional capability for this kind of profession. Your evaluations have been reflective of this. I argued that I had other evals from CRNAs and attendings that gave me positive evals(more than the negative ones even) I even said that being in the code team I've shown how I can handle myself in stressful situations and have been lookd at as a strong resource by the residents and nurses alike.

MK then steps in in a role that is far from supportive.

Then MK (who said "well there was consistency in the other evals that showed unsatisfactory marks. And it's difficult to transition to this new field especially that you've been in a nurse for so long ; it's just a whole different challenge "

Still, at this point, I thought maybe MK thought it was a fair and relevant contribution.

Theme of turning my ICU experience into a liability

This has been another point that they have tried to push on me - turning my experience and success as an ICU nurse into a liability. Every person OUTSIDE of MK and Ray (including pretty much every single anesthesiologist I have ever spoken to about my desire to become a CRNA) has said that there is no single thing that will be more valuable than my lengthy experience in the unit.

Ray tells me that even when I do return, I can only expect even rougher treatment by the CRNAs.

He also tells me an anecdote to point out just how little they want me there: Ray said, "When you come back the CRNAs are going to look at you differently. And it's human nature so I don't have control of how they're going to behave towards you. As a matter of fact before this meeting I told one CRNA that I was about to meet with MK and you and she said, 'She's not coming back is she?'

Ray continues on the theme of how little I am wanted.

"And I think if I took a poll from the CRNAs I have a feeling that they would unanimously vote to not have you return.

MK steps in again to elaborate on this theme:

MK then chimed in and said, " I actually had a meeting with them this week and many showed their skepticism regarding Maricel's return. Ray said, "See realize what you're up against; it will be more than an uphill battle for you and if you made a mistake it would be looked into with more disdain than when you first committed them." How do you explain to them that your so far behind and your classmates are way ahead of you now?" Also what kind of example am I setting by allowing you to come back, it lowers down the high standards that we had set before and what Rush is known for." Right now the SRNAs who are working down there are measured in a very high level of expectation. The anesthesiologists are surprised when they actually meet them and even then they push the expectations even higher so imagine facing that. "

Ray establishes that I shouldn't even consider trying to go elsewhere: (Why is he worried about this? I had never mentioned anything along those lines). "Anesthesia is a very small world , if you hiccup in the east coast we will hear about it here even before you say excuse me. Quitting the program does not mean that you were not successful, you can be successful but just NOT in anesthesia. Have you looked into other NP programs?. If you transition now it would be easier to get into other programs than if you waited until you fail out later and we're just looking at the inevitable, I'm just gonna tell you later, "see I told you so".

Trying to get me to just walk away

He then asked MK, Mike how many people transfer from their initial program to another program within the various NP programs? MK then said, "Oh countless times!"

Ray then refers to my age.

"See, find out where you can be truly successful and be happy there. I don't suppose you are the youngest in your class so why waste your time on something that will make you miserable just try to be happy and find that place where you can be a good fit? I'm sorry I've upset you but you need to hear the truth, the people who are not telling you this don't care about you because they're not letting you see your shortcomings, they're not being honest to you.

Accusation that I have been running around and around just so I can find someone who tells me what I want to hear. I have no idea where he gets this from either.

You're like somebody who goes from doctor to doctor so you can get feedback that you want to hear and before too long it's too late and the cancer has spread. So, LISTEN to what MK has to say, listen to his advice and open your eyes don't use your heart and it's not enough that you wish or desire this you have to be qualified to do this!"

Ray wants me to know that he really is on my side:

He then ended with "You know, when you graduate send me an invitation and I would be there to congratulate you".

Out of Ray's presence, MK reassures me that in fact, he too really is on my side.

So we left as I kept fighting back the tears and MK pulled me aside a corner where he said he wants to talk to me privately. He started with "Well I'm told

that I tend to soften things and make things sound less severe. I certainly was not expecting Ray's approach where he just slammed you and slammed you with all these things. It's definitely a lot to process right now so why don't you take some time to think things through because I'm certainly not expecting you to make this major decision right now. Let's say that in two weeks get back to me on your decision.

MK reiterates that I really don't have a shot:

He then left me with "As Ray said it will be more than an uphill battle for you and we just want you to be happy."

And suddenly it was all warm and supportive. He hugged me and then said, you're a good person just try to find your happiness. Are you are going to be ok driving back home?"

I said yes I'll be fine, and thanked him for his time.

EXHIBIT

A23

THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

MARICEL MARCIAL,)	
)	
Plaintiff,)	
)	
-vs-)	No. 16-CV-06109 5106
)	
RUSH UNIVERSITY MEDICAL CENTER,)	
et al,)	
)	
Defendants.)	

The deposition of THOMAS G. HOLMES, M.D., taken pursuant to the provisions of the Code of Civil Procedure and the Supreme Court Rules of the State of Illinois pertaining to the taking of depositions for the purpose of discovery, taken before DEANNA L. TUFANO, Certified Shorthand Reporter of the State of Illinois, at 1775 Ballard Road, Park Ridge, Illinois, on March 12, 2018 at 1:00 p.m.

Reported for:

MAGNA LEGAL SERVICES

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Deanna L. Tufano, C.S.R.

Page 2

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Chicago, Illinois 60606

(312) 655-1500

on behalf of the Defendants.

REPORTED BY: DEANNA L. TUFANO, CSR

LICENSE NO. 084-003819

Page 4

(Witness sworn.)

THOMAS G. HOLMES, M.D.,

called as a witness herein on behalf of the Defendant,
having been first duly sworn, was examined and testified
as follows:

EXAMINATION

BY MS. COURTHEOUX:

Q Good afternoon. Thanks again for being here and
bearing with us through your technical challenges which
seem to have been resolved.

Dr. Holmes, have you had your deposition taken
before?

A Yes, I have.

Q Great. We will go over that in a few minutes.

Before we do that, I just wanted to review a
few ground rules with you. First, you should be familiar
since you've had your deposition taken before, please let
me finish the question before you begin your answer.
That way you'll know that you've heard the full question
and we'll know the question you're answering is the same
one that I asked; is that okay?

A Yes.

Q Also it should be obvious from the set up your
answers should be audible. Please speak up so we can

Page 3

INDEX

WITNESS

PAGE

THOMAS G. HOLMES, M.D.

Examination By Ms. Courtheoux..... 4

Examination By Ms. Siegel..... 32

Further Examination by Ms. Courtheoux. 36

EXHIBITS

NUMBER MARKED
FOR ID

Packet of documents were referred to but not
marked during deposition

Page 5

hear you and speak in words not gestures, okay?

A Okay.

Q We ask that you provide full and complete answers
to our questions. Also, if you don't understand a
question, please say so. If you answer a question, I
will assume that you understood what I meant, okay?

A Okay.

Q Please let us know if you feel you need a break
we can take one. I would just ask that you finish
answering the question that's on the table before we take
any break, fair?

A Yes. Absolutely.

Q Finally, are you taking any medications or are
there any other circumstances that might make it
difficult for you to understand and answer my questions
today?

A No, I am not.

Q Thank you. I understand that there's a packet of
documents for us to use as exhibits with you.

A Yes. I have it here.

Q Excellent. I have given the same packet to
Plaintiff's Counsel and to Plaintiff, and they are in the
page numbered order that we received them.

So to get started, would you mind please just

Page 6

1 walking us through your educational background?

2 A I graduated medical school at Northwestern. I
3 did my residency also at Northwestern and have been
4 practicing primary care internal medicine since then.
5 That was in 1984.

6 Q What was the specialization of your residency?

7 A Internal medicine.

8 Q THANK you. And would you mind reviewing your
9 employment history since you graduated from medical
10 school from residency?

11 A Sure. I initially was an attending physician at
12 the VA Lakeside Hospital which was the VA associated with
13 Northwestern. I spent about four years there, and then I
14 joined the medical center, the teaching practice for
15 Lutheran General Residency Program, and I've been there
16 ever since.

17 Q Thank you. And you're licensed to practice
18 medicine in the State of Illinois?

19 A Yes.

20 Q Are you board certified?

21 A Yes.

22 Q In what area?

23 A Internal medicine.

24 Q Thank you. And any history of professional

Page 7

1 discipline, any suspension of your license, reprimand,
2 anything like that?

3 A No.

4 Q How would you describe the nature of your medical
5 practice?

6 A I practice general internal medicine diseases of
7 adults, so we basically diagnose and treat problems
8 associated with aging, chronic medical problems like
9 diabetes and hypertension and spend a fair amount of time
10 trying to accomplish preventative care to prevent people
11 from getting sick.

12 Q How many providers are in your practice?

13 A There are 8 attendings and 54 residents.

14 Q And had you met or did you know Ms. Marcial in
15 any capacity before she came in as a patient?

16 A She's a nurse on the intensive care unit over at
17 Lutheran, so I had met her in that context.

18 Q How often would you say you interacted before she
19 became your patient?

20 A Maybe once a month.

21 Q Now, let's turn back to the other depositions
22 you've mentioned. How many depositions have you given?

23 A I guess it must be near 20.

24 Q And how many of those were you an expert witness?

Page 8

1 A 18.

2 Q What about the other two?

3 A The other two were suits against me or my
4 practice.

5 Q Can you give me the approximate dates of those
6 two lawsuits?

7 A The first one was in 2000. The second one was, I
8 want to say, 2006, 2005, somewhere around there.

9 Q And for each of those, could you just briefly
10 describe what the claims were?

11 A For the first one the claim was that patient who
12 came in under my care suffered adverse outcome with
13 permanent vegetative state after pneumococcal infection.

14 Q And what was the resolution of that case?

15 A It was settled.

16 Q Thank you. How about the second one?

17 A Second one was an older gentleman who came to the
18 office complaining of chest pain. We determined it was
19 non-cardiac and sent him home, and then he subsequently
20 had an acute MI and passed away.

21 Q And how was that resolved?

22 A It was dismissed.

23 Q Okay. Dr. Holmes, thank you very much.

24 Just to clarify, you're here for your deposition

Page 9

1 pursuant to a subpoena issued by the Defendants, issued
2 by me as their attorney?

3 A Okay.

4 Q And did you also provide documents to us pursuant
5 to a separate subpoena?

6 A This is the only one I know about.

7 Q Well, the documents that I sent that I have in
8 front of you, are those documents that your office
9 produced to us?

10 A Yes. I recognize them.

11 Q Can you just explain how those documents were
12 identified and produced?

13 A Well, not being involved in it myself, I will do
14 the best I can. These are basically the clinical
15 summaries of the visits for Ms. Marcial. They are not
16 the -- at least several of them are just the clinical
17 summaries which basically say why she was here and what
18 was done. And subsequently, several of these are
19 actually the notes themselves. The clinical summary is
20 kicked out of the actual note. And then later on, we
21 have actual notes that are printed up.

22 Q Okay. Thanks. I'd like to start walking through
23 your treatment of Ms. Marcial. I understand that in the
24 course of your practice, you've had occasion to treat

Page 10

Page 12

1 Maricel; is that correct?

2 A Yes.

3 Q Do you know how it came to pass that Maricel
4 sought out your practice?

5 A I do not.

6 Q When did you first see her?

7 A I've only actually seen her personally on one
8 occasion. Most of these notes are from a variety of
9 sources including the family practice residents as well
10 as some of the internal medicine residents. So my name
11 is on a lot of these that we ordered to try and evaluate
12 what was going on. You know, she also has notes from an
13 AMG practice down on the south side, 2545 South Martin
14 Luther King Drive which is a completely separate
15 facility. So I believe that the one time I saw her and
16 wrote a note was a visit with one of the residents. I am
17 not sure I can locate that right now. Anyway, I should
18 have marked these up. You said I didn't have to read
19 them, and then I should have read them.

20 Q I am just asking for your recollection at this
21 point. It sounds like you seen her as a patient just
22 once and you're not sure exactly when that was; is that
23 correct?

24 A Correct. It's in here somewhere, but I am having

Page 11

1 difficulty locating it at this moment.

2 Q That's okay. As we go through some of these
3 documents, we won't go through all of them, but as we
4 walk through some of them, if you could please point out
5 the one where you actually interacted with Maricel, that
6 would be great?

7 A I would be happy to do so.

8 Q Thank you.

9 Is it routine in your practice that Maricel,
10 although she is your patient, would see your colleagues
11 instead when she comes for office visits?

12 A Yes. That's routine. We run a residency
13 training practice here, so our goal is to get as many
14 patients into the care of the residents as possible.

15 Q What is your relationship to Maricel's treatment
16 for the times when you didn't actually interact with her
17 in the office, would you have find out that she had been
18 in or did you oversee her treatment at all personally?

19 A I would either get a note from the resident who
20 saw her or supervise the visit myself.

21 Q What would it mean to supervise the visit
22 yourself?

23 A Well, the resident sees the patient and then
24 presents the case to me. We discuss the treatment plan,

1 and depending on the resident's level of skill, we
2 implement that. With the second and third year
3 residents, I don't really need to do much most of the
4 time. But for the first years, we interact very closely
5 with ordering tests and discussing results and that sort
6 of thing.

7 Q Okay. Thank you.

8 So you might notice that these documents all
9 have page numbers in the lower-right corner.

10 A Yes.

11 Q We'll be relying on those page numbers.
12 Unfortunately, that means we will not be proceeding
13 exactly in order in the sequence that they are stacked,
14 but the page number should help us to stay on the same
15 literal page.

16 If we can start actually at Page 97.

17 A Okay.

18 Q Do you recognize this record?

19 A It's lab sheet, a CBC ordered by Sharon Decker
20 who was a resident here at the time. It was a long time
21 ago. That was in 2007.

22 Q Yes. What was the date of that lab work?

23 A 10/29/2007.

24 Q And who created this record?

Page 13

1 A I don't know what that means. This is a page
2 from our EMR. This is how the labs are presented in our
3 electronic medical record.

4 Q So this is just a set of lab results?

5 A Correct.

6 Q Thank you.

7 So is it fair to say that this would not have
8 been an office visit, but rather just an independent lab
9 visit by Maricel?

10 A I would guess that this was probably an office
11 visit with Dr. Decker, and then she went and had these
12 labs done. It's difficult to say without seeing the rest
13 of the workup. I mean, it's certainly possible it was an
14 independent lab test as well.

15 Q Thank you. Excuse me one moment.

16 Can you please turn to the document beginning
17 with Page 87.

18 A Okay.

19 Q Do you recognize this document?

20 A This is a note from August 11, 2009. It appears
21 to have been written by Dr. Mark Conley who is my
22 partner.

23 Q Would you say that this record was kept in the
24 course of the regularly conducted business activity in

Page 14

Page 16

1 your practice?

2 A Yes.

3 Q Would this document have been created at or near
4 the time of the event that it records?

5 A It certainly appears to be. She was in a car
6 accident on August 9th and came to see us on August 11th,
7 so that's two days.

8 Q Would you answer the same way for any medical
9 records kept by your practice with regards --

10 A I don't understand the question.

11 Q I am just wondering whether records like this
12 one, you said that it was notes from her visit with Dr.
13 Conley. Would any similar note of Maricel's visits to
14 providers in your practice --

15 MS. SIEGEL: I am going to object. Lack of
16 foundation for records for all the documents.

17 MS. COURTHEOUX: Counsel, do you mean I should go
18 through it one by one and authenticate --

19 MS. SIEGEL: No. I am saying that there are items in
20 here that don't constitute business records. They
21 contain matters that are out of the scope of business
22 records.

23 BY MS. COURTHEOUX:

24 Q Doctor, would you please turn to Page 88 which is

Page 15

1 the second page of this packet?

2 A Yes.

3 Q Can you tell what the reason for Maricel's visit
4 on August 11, 2009 was?

5 A Yes. She was complaining of neck and shoulder
6 soreness after a motor vehicle accident two days prior.

7 Q And under active problems, what are the active
8 problems noted in this record?

9 A Well, she had a breast mass that had been
10 identified, and she has a history of palpitations.

11 Q Do you know anything else about Maricel's history
12 of palpitations?

13 A Not based on this particular record, no.

14 Q How about based on your recollection of treating
15 her?

16 A I don't recall any issues with palpitations.

17 Q Did Maricel attribute her palpitations to any
18 particular cause when she visited on August 11, 2009?

19 A I don't believe her palpitations were discussed.

20 Q Is it fair to say that her palpitations predated
21 her visit on August 11, 2009?

22 A Yes.

23 Q Are palpitations considered cardiovascular
24 symptoms?

1 A Yes, they are frequently.

2 Q When patients come in for a reason other than
3 cardiovascular symptoms, do you ask about cardiovascular
4 symptoms as a matter of course?

5 A It depends on the situation. Sometimes you
6 would, sometimes you would not.

7 Q Could you please turn the packet that begins with
8 Page 92, but we're actually going to look at Page 94.

9 A Okay.

10 Q What is this document?

11 A This document is a note from a gynecologist who
12 was Dr. Daniel Pesch from August 6, 2008.

13 Q Was Maricel in the office for a visit on August
14 6, 2008?

15 A Yes. In the gynecologist office, yes.

16 Q Now on page 94, there's a section called ROS.
17 What does that stand for?

18 A Review of systems.

19 Q And under cardiovascular symptoms, does it say no
20 cardiovascular symptoms?

21 A Yes, it does.

22 Q Did that mean that Maricel did not complain of
23 palpitations when she was in that day?

24 A It appears that's the case.

Page 17

1 Q Did it tell you anything about her history of
2 palpitations?

3 A It does not.

4 Q Could you please turn to the packet that starts
5 with Page 49.

6 A Absolutely. Okay.

7 Q Okay. What is this document?

8 A This is a document where the patient presented
9 complaining of palpitations and lightheadedness. This
10 was on 4/2/2014. She was seeing Dr. Kimberly Tran who
11 was one of our residents at the time, and I was the
12 supervising physician.

13 Q So the reason for the visit was complaints of
14 lightheadedness and palpitations; is that correct?

15 A Yes.

16 Q On Page 51, what does it mean when it says acute
17 care note at the top?

18 A Means that it was not a chronic care or follow-up
19 visit. It was for an acute problem.

20 Q If we look down, there's a heading that says HPI,
21 what is HPI?

22 A History of present illness.

23 Q And it says that Maricel had a past medical
24 history of PVC; is that correct?

Page 18

Page 20

1 A It does.

2 Q What does that mean?

3 A Means that she had a past medical history of
4 premature ventricular contractions, a common problem
5 that's often associated with the sensation of
6 palpitations.

7 Q Does a past medical history of PVCs make it more
8 likely that a patient would experience palpitations
9 again?

10 A Well, I don't know that you can make a blanket
11 statement about that. A lot of the sensation of
12 palpitations are related to the state of arousal of the
13 patient, so somebody who is under a lot of stress, may be
14 more conscious of any premature beats that they're
15 having. People who are not under stress will often not
16 notice them. So the answer is, depends on the patient's
17 state of mind.

18 Q Now also under HPI, there is a statement here,
19 patient states that she has been stressed out a lot with
20 school. Patient states there's been a lot of bully in
21 her class.

22 A Yes.

23 Q What do those statements reflect?

24 A I believe they reflect the state of mind that the

1 page, the following, following page. Seen in office
2 today for workup for palpitations and lightheaded.

3 Please excuse patient from school for the next week until
4 she is medically cleared from us to return back to
5 school.

6 Q Did Maricel say anything else about her
7 experience at school that day?

8 A I don't honestly remember. I think I wrote down
9 pretty much what I had taken out of it. She was very
10 upset.

11 Q I take it that Maricel said she was feeling
12 stressed?

13 A Correct, yes.

14 Q Did she say whether she was stressed because she
15 had been performing poorly at school?

16 A I did not ask that question. I don't know.

17 Q Did she say whether she was stressed because she
18 was at risk of failing out of the program?

19 A Again, I did not pursue those aspects of her
20 stress.

21 Q Why was she stressed?

22 A Well, anybody who's working in the ICU and going
23 to school I don't know how much class time she had, but
24 it's a stressful situation. I have the opportunity to do

Page 19

Page 21

1 patient was in. She was very upset. She felt that she
2 was not getting the support that she needed from the
3 class that she was taking. If I recall, this is the
4 visit where I went in and talked to her and she, I
5 believe, was tearful and very upset about her school
6 situation.

7 Q So those comments that I just referred to, those
8 are Maricel's subjective impressions that she was
9 relaying to you about how she was feeling?

10 A Yes.

11 Q Well, since you spoke with her, can you describe
12 what she told you?

13 A Well, I think I wrote it down at the end of this
14 note. On Page 54 at the bottom it says, seen and
15 discussed at time of visit, patient with complaints of
16 dizziness and palpitation. She is under a lot of stress
17 at school, feels she is being misused. Tearful and
18 depressed. Has normal exam, some nystagmus with dicks
19 hallpike which means that some of the symptoms that she
20 was having are probably relating to a benign but
21 disturbing disorder of the inner ear. Agree with plan,
22 trial of Bupropion and follow-up as noted. So follow-up
23 with included some blood tests, a 2D echo and a note
24 given for school which is on the page, the following

1 clinical teaching with some of the nurse practitioner
2 student and most of them are under a tremendous amount of
3 stress, both financially and time-wise. I did not pursue
4 the degree of stress that she was under at this time. I
5 did recommend that she get started on something for
6 depression which would be the Bupropion, and we would
7 bring her back in a few weeks and see how she was doing.

8 Q Is it fair to say that you don't know exactly why
9 she was stressed that day?

10 A That is fair.

11 Q Other than that, it had to do with school?

12 A That is correct. She did say she felt she was
13 being misused or being treated unfairly. I did not
14 explore that issue anymore than that.

15 Q Going back to Page 51, that statement that we
16 read before, patient states that there has been a lot of
17 bully in her class.

18 A Yes.

19 Q Dr. Holmes, who was bullying Maricel?

20 A I don't know. I don't know whether she's talking
21 about people in her class or the teachers or I don't
22 know. I have no insight into that.

23 Q Okay. I think you have referred to Page 54
24 previously. Let's turn back to that if you can.

Page 22

1 Could you please explain what's written under
2 the word vertigo at the top?

3 A Vertigo most likely BPPV, which stands for benign
4 paroxysmal -- I'll think of it in a second. That's the
5 benign vertigo that we often see in certain disorders of
6 the vestibular apparatus. Benign paroxysmal positional
7 vertigo.

8 Q And how about under where it says anxiety just
9 under vertigo?

10 A Yes.

11 Q Can you explain what's written there?

12 A It says, will try Bupropion 150 milligrams daily
13 for a week and then increased to BID.

14 Q What is BID?

15 A BID means twice a day.

16 Q And what is that medication?

17 A Bupropion is an antidepressant and anti-anxiety
18 medication that we frequently use in young people because
19 it has fewer side effects than some of the other
20 medications.

21 Q What are the side effects that it has, if any?

22 A Of the Bupropion, probably the most serious side
23 effect is that it lowers the seizures threshold and can
24 make people who have a history of seizures have seizures.

Page 23

1 Other than that, it's really a very well-tolerated drug
2 in excess can cause some dizziness or lightheadedness.
3 But overall is a pretty well tolerated medication.

4 Q And I see you also noted here and discussed that
5 Maricel was tearful and depressed; is that correct?

6 A Yes, that's correct.

7 Q What was the cause of Maricel's tearfulness and
8 depression?

9 A Something going on at school I believe was the
10 main issue.

11 Q Could it have made Maricel tearful and depressed
12 if she felt ashamed of mistakes she's made in caring for
13 patients in the clinical setting?

14 MS. SIEGEL: I am going to object. Calls for
15 speculation.

16 BY MS. COURTHEUX:

17 Q You can answer.

18 A I could imagine that it would make anybody who is
19 clinically oriented tearful and depressed, yes.

20 Q And if Maricel had felt ashamed that she hadn't
21 performed well enough to successfully complete her
22 residency, could that have made her feel and depressed?

23 A Yes.

24 Q Let's turn back to Page 50 which you eluded to

Page 24

1 earlier. What is this document?

2 A This is a letter for Maricel to take to her
3 school.

4 Q And was this issued by Dr. Tran?

5 A Yes. It was under my guidance.

6 Q Why did you request that Maricel be excused from
7 school?

8 A Well, I think because she was so upset and
9 tearful and distraught that it was -- since that seemed
10 to be the source of her distress, that it would be good
11 to get away from that for a while. It's sort of like an
12 excuse from work note.

13 Q And why was it for the next week, why not a
14 shorter or longer period?

15 A It's all hocus-pocus, I don't know. We kind of
16 have to judge based on what's going on, how much time
17 they need, how do we tell anybody they need two weeks off
18 for their back injury. It's kind of negotiation with the
19 patient.

20 Q What treatment was prescribed for Maricel on
21 April 2, 2014?

22 A Well, she was given Bupropion to take it once a
23 day for a week and it increased to twice a day. A number
24 of tests were ordered to see if there was any metabolic

Page 25

1 cause for some of her symptoms, as well as an
2 echocardiogram to see if there was any issues with the
3 palpitations that may be related to something within her
4 heart.

5 Q Now Dr. Holmes, if you wouldn't mind turning to
6 Page 16, please. That's the front of the packet. I am
7 sorry to jump around. I am just trying to go
8 chronologically.

9 A All right. Page 16. Here we go.

10 Q Okay. What is this document?

11 A This document is a clinical summary that is
12 prepared from the note that we just reviewed.

13 Q I see. Can you just explain the relationship
14 between those two documents?

15 A Yes. The relationship here is that the clinical
16 summary is something that is given to the patient when
17 they leave which includes various reasons for being there
18 and what was talked about and what their vital signs were
19 and sort of a summary of the visit without all of the
20 language.

21 Q Thank you. And now can we please turn to Page
22 45.

23 A Okay.

24 Q What is this document?

Page 26

1 A All right. This is a report of an echocardiogram
2 that she had, I think. Well, it's actually labs and
3 labs. So there is no echocardiogram in here. So these
4 are basic metabolic panels, a blood count and a thyroid
5 test that was ordered by Dr. Tran in the appointment that
6 we previously discussed.

7 Q And would these tests have been run on April 3,
8 2014?

9 A Probably so. April 3rd looks like when she went
10 to get the blood drawn, yeah.

11 Q What were the results of these test generally
12 speaking?

13 A They were normal. Her blood sugar was a little
14 bit high, but it was a non-fasting test and her blood
15 counts and thyroid tests were normal.

16 Q Okay. Next please turn to Page 40.

17 A Okay.

18 Q What is this document?

19 A This is a result of labs done on April 2, 2014 --
20 ordered on April 2, 2014. So these are the same labs as
21 the other one.

22 Q I see. So these reflect normal results of the
23 same lab tests that were done?

24 A Correct. This also included the echocardiogram

Page 27

1 that was obtained. This was done apparently the
2 following day, and the echocardiogram was basically
3 normal.

4 Q Was there anything abnormal about it?

5 A There's a trivial pericardial effusion that has
6 no significant meaning and everything else was normal.

7 Q When was Maricel's next visit after April 3,
8 2014?

9 A I don't have her complete chart here, so I really
10 can't tell you. There appears to be one here of April
11 2nd. The August 10, 2012, that's going the wrong
12 direction, so I actually don't know.

13 Q Maybe I can help. Would you mind turning to Page
14 13?

15 A Okay.

16 Q What is this document?

17 A This is a clinical summary, in other words the
18 shortened form from an appointment with Dr. Zang or Dr.
19 Zong, I am sorry. That was 4/11/2014.

20 Q What was the purpose of this visit by Maricel?

21 A Well, I would have to actually look at the note I
22 believe that it looks like they discussed her anxiety.
23 There's not enough detail in here for me to say what the
24 purpose really was. Do we have the note?

Page 28

1 Q Actually, yes. Why don't we supplement that one
2 and look at the same time at Page 35, maybe that will
3 help.

4 A All right. Here we go.

5 So she was following up from the visit the
6 previous week. She states that her lightheadedness has
7 gotten worse. Having nausea, dizziness which seems to be
8 related to probably her benign paroxysmal positional
9 vertigo. So she was here with worsening dizziness.

10 Q Were there any tests ordered or run in connection
11 with this visit by Maricel?

12 A It appears that we did not do any tests.

13 Q Sorry. It looks like you said something but we
14 didn't hear anything come through.

15 A Okay. What was the question again?

16 (Question read.)

17 BY THE WITNESS:

18 A No, there were not.

19 BY MS. COURTHEOUX:

20 Q On Page 36, there's a page that says letter at
21 the top. What is this letter?

22 A This is another letter to her school stating that
23 she could return to her normal educational and clinical
24 duties. So she was seen a week before, told to take a

Page 29

1 week off, we saw her back in a week, and her symptoms
2 were better and she was able to return back to work.

3 Q So her lightheadedness or dizziness was not
4 concerning enough that you recommended she remain out of
5 school or clinical work; is that correct?

6 A That's correct.

7 Q Has Maricel come back in for treatment of her
8 vertigo or for anxiety or dizziness since April 2014?

9 A Of my knowledge, no.

10 Q And Dr. Holmes, in the period from 2012 to 2015,
11 did Maricel complain of pain?

12 A Not that I know of, no.

13 Q And during the same period from 2012 to 2015, did
14 Maricel complain of physical injury?

15 A I don't know of any incident, although she was in
16 a car accident. I don't remember when that was. I don't
17 think that was -- I don't think that's what you're
18 referring to.

19 Q And Dr. Holmes the documents that your office
20 produced in response to our subpoena which as we've
21 looked at today consists of clinical summaries and notes
22 and related documents. Do you find these to be reliable
23 reflections of what happened when Maricel interacted with
24 providers in your office?

Page 30

Page 32

1 A Yes, I do.
 2 Q Just going to take one minute to look over my
 3 notes if that's okay. I'd like to clarify one more
 4 thing, then I will wrap up my questioning. If we go back
 5 to that very first set of notes beginning with Page 97.
 6 Could you let me know when you get there?
 7 A I have it.
 8 Q Thank you.
 9 So actually turning into that document at Page
 10 99 in the middle of the page.
 11 A Yes.
 12 Q There's a heading that says diagnoses?
 13 A Yes.
 14 Q Can you tell me what the diagnosis was on this
 15 day which is October 29, 2007?
 16 A The diagnosis is palpitations.
 17 Q Does Maricel attribute her palpitations in 2007
 18 to any particular cause?
 19 A I don't have an answer to that question because I
 20 don't actually have the note that would be associated
 21 with this, so I can't answer that question whether it was
 22 attributed to anything.
 23 Q How likely is it that anxiety or stress caused
 24 her palpitations in 2007?

Page 31

1 A I am not aware of anxiety or stress she was
 2 experiencing then, so I can't really answer that
 3 question. I don't know what her life was like at that
 4 time.
 5 Q But there were labs conducted that day; is that
 6 correct?
 7 A Yes.
 8 Q And what were the results of those lab tests?
 9 A They were normal.
 10 Q Do you know if there was a physical exam that day
 11 as well?
 12 A I am sure there was, but I don't see it in these
 13 records. All these are are the labs and they were
 14 normal.
 15 Q Okay. And when the lab tests are normal, what
 16 does that mean about the cause of palpitations? Does
 17 that give you any insight into what might be causing
 18 them?
 19 A Only if they're abnormal. A bunch of normal labs
 20 is what I would expect to get from a young lady in good
 21 health. That's kind of what usually we find. So the
 22 cause of the palpitations is often or usually
 23 multifactorial. It might be related to stress. It might
 24 be related to lack of sleep or any number of physical and

1 psychological factors.
 2 MS. COURTHEOUX: Okay. That's all I have. Thank
 3 you, Dr. Holmes.
 4 A You're welcome.
 5 MS. SIEGEL: If I can take a minute. I have a couple
 6 follow-up questions.
 7 MS. COURTHEOUX: No problem.
 8 MS. SIEGEL: Let's take a short break.
 9 (Short recess.)
 10 EXAMINATION
 11 BY MS. SIEGEL:
 12 Q Good afternoon, Doctor, ready to go back on the
 13 record?
 14 A Yes.
 15 Q My name is Elaine Siegel and I am the attorney
 16 for the Plaintiff in this matter, Maricel Marcial. I
 17 have a small handful of follow-up questions. Thank you
 18 very much for sitting with us this afternoon.
 19 Now, you have testified that you saw Ms. Marcial
 20 periodically over a multi-year period; is that right?
 21 A Yes.
 22 Q And during that time, she did not consistently
 23 present with vertigo; isn't that correct?
 24 A That is correct.

Page 33

1 Q And she did not consistently present with
 2 palpitations; isn't that right?
 3 A That is also correct.
 4 Q Is it fair to say that in Ms. Marcial's case, the
 5 palpitations were intermittent?
 6 A Yes.
 7 Q And is it fair to say that her bouts of vertigo
 8 also were intermittent?
 9 A Yes. As far as I know, it was fairly consistent
 10 in that time frame that we spoke about. I don't know
 11 whether she's been having other bouts of vertigo or not.
 12 Q They didn't come to your attention; is that
 13 right?
 14 A Correct.
 15 Q Your notes reflect that tests were performed on
 16 Ms. Marcial for the vertigo, right?
 17 A Yes.
 18 Q And is it correct that one of those tests was
 19 something -- I am not going to pronounce it correctly.
 20 I'll try. The dicks hallpike maneuver?
 21 A Yes.
 22 Q Can you explain for the record what the dicks
 23 hallpike maneuver consist of?
 24 A The dicks hallpike maneuver is a series of

Page 34

1 movements that we use to diagnose benign paroxysmal
2 positional vertigo consists of lying a patient down very
3 quickly on the table and turning their head one direction
4 or the other in order to try and generate vertigo. And
5 more importantly nystagmus which is an indication that
6 the vestibular system is not working right.

7 Q Can you explain for us please what nystagmus is?

8 A Nystagmus is a rapid eye movement. Usually it's
9 a classically thought of saccade, S-A-C-C-A-D-E which is
10 where the eye moves rapidly in one direction and then
11 slowly back and rapid back, back and forth.

12 Q And when the dicks hallpike maneuver induces
13 nystagmus, is that an objective indication of vertigo?

14 A It's an objective identification of a peripheral
15 vertigo which we usually associate as being this BPPV
16 that we have spoken about.

17 Q Did you have any reason to believe that Ms.
18 Marcial was malingering when she complained of vertigo?

19 A No.

20 Q And now when it comes to the palpitations, do you
21 have any reason to believe that Ms. Marcial was
22 malingering when she spoke of suffering from
23 palpitations?

24 A No.

Page 35

1 Q We have talked about two periods today in which
2 Ms. Marcial came to you with complaints of vertigo and a
3 palpitations; isn't that right?

4 A Yes.

5 Q And one was associated with the car accident;
6 isn't that right?

7 A Yes.

8 Q And the other Ms. Marcial reported to you that
9 she was experiencing high levels of stress in the course
10 of her studies; isn't that right?

11 A That is true.

12 Q And is it fair to say that stress can precipitate
13 palpitations?

14 A Yes. I think that's something that we have all
15 seen, many of us have experienced.

16 Q And when you say that's something that we have
17 all seen, do you mean that internal medicine
18 practitioners have seen that?

19 A Yes.

20 Q And you testified that that was multifactorial
21 often times; is that right?

22 A It's usually multifactorial, yes.

23 Q So the palpitations are frequently a
24 multifactorial condition; is that correct?

Page 36

1 A Yes.

2 Q Did you explore with Ms. Marcial other
3 contributing factors in addition to the stress that she
4 was experiencing in connection with her studies?

5 A Yes. We sent labs off to make sure she wasn't
6 suffering from thyroid disease or any kind of electrolyte
7 abnormalities, anemia, that sort of thing as part of the
8 workup.

9 Q And those were negative; is that right?

10 A Those were all normal.

11 Q And was there a practitioner associated with your
12 practice named Dr. Dennis Moore?

13 A Dr. Dennis Moore was an ear, nose, and throat
14 physician that did a lot of work with dizziness and
15 vertigo.

16 Q Do you recall whether you referred Ms. Marcial to
17 Dr. Dennis Moore?

18 A I did not.

19 MS. SIEGEL: Thank you. I have nothing further.

20 MS. COURTHEOUX: If I can clarify one more thing for
21 the record, please.

22 FURTHER EXAMINATION

23 BY MS. COURTHEOUX:

24 Q Doctor, Ms. Siegel asked to you confirm that

Page 37

1 there were two periods in which Maricel complained of
2 palpitations, vertigo and palpitation. But let's concern
3 ourselves just with palpitations for now. One period
4 associated with a car accident and another I think
5 referring to school stress experienced in April 2014; is
6 that correct?

7 A Yes.

8 Q When you listen to Ms. Siegel's question about
9 the car accident and you agreed that that was one of the
10 periods in which Maricel experienced palpitations, were
11 you referring to the car accident that's referred to in
12 the notes about Maricel's visit on August 11, 2009,
13 that's reflected in the packet starting with 87?

14 A 87, that's what I needed. I believe that is what
15 I was referring to. I guess I should look and see here.
16 I don't see anything in this content here about vertigo
17 or palpitations actually. This was really more of a
18 musculoskeletal --

19 Q This was the car accident that you had in mind
20 when you answered Ms. Siegel's questions?

21 A Yes.

22 Q On Page 88 under active problems, I think we
23 noted that the word palpitations appeared there in the
24 middle of the page; is that correct?

Page 38

1 A That is correct.

2 Q Now for active problems, does that suggest a
3 problem that arose with the car accident that led Maricel
4 to come in or does that suggest a previous condition that
5 was ongoing at the time when she came in?

6 A A previous condition that was ongoing --

7 MS. SIEGEL: Objection. Calls for speculation.

8 BY MS. COURTHEOUX:

9 Q And just one more thing, Dr. Holmes. So this car
10 accident that you were referring to in answering Ms.
11 Siegel's question that's August 11, 2009, or therabout.
12 But when we looked at page the packet beginning with 97,
13 specifically Page 99, we noted that there was a diagnosis
14 of palpitations then, too; is that correct?

15 A Yes.

16 Q And that was in 2007 a couple years before the
17 car accident you were thinking of?

18 A Yes.

19 Q Does that change your assessment with whether Ms.
20 Siegel has the timing right that there were two periods
21 in which Maricel complained of palpitations?

22 A Yeah, I think it probably does. I don't see
23 anything in this 2009 note about complaining of
24 palpitations or vertigo at that time. She was

Page 39

1 complaining of neck and shoulder pain, but nothing there
2 about palpitations.

3 Q So the two periods of palpitations if there were
4 just two periods, would have been closer to October 2007
5 and then again April 2014?

6 A Yes. I think that's probably correct.

7 MS. COURTHEOUX: Thank you. That's all I have.

8 THE COURT REPORTER: Signature?

9 MS. COURTHEOUX: Would you mind explaining the
10 question to him?

11 THE COURT REPORTER: Would you like to reserve or
12 waive signature?

13 THE WITNESS: I usually reserve signature.

14 * * * * *

Page 40

REPORTER'S CERTIFICATE

2 The within and foregoing statement of the
3 witness, THOMAS G. HOLMES, M.D., was taken before DEANNA
4 L. TUFANO, CSR, and Notary Public, at 1775 Ballard Road,
5 in the City of Park Ridge, Cook County, Illinois, at 1:00
6 o'clock p.m. on the 12th of March, A.D., 2018.

7 The said witness was first duly sworn and was
8 then examined upon oral interrogatories; and the
9 questions and answers were taken down in shorthand by the
10 undersigned, acting as stenographer and Notary Public;
11 and the within and foregoing is a true, correct, and
12 accurate record of all of the questions asked of and
13 answers made by the said witness, THOMAS G. HOLMES, M.D.,
14 at the time and place hereinabove referred to.

15 The undersigned is not interested in the within
16 case, nor of kin or counsel to any of the parties.

17 Witness my official signature and seal as Notary
18 Public in and for Cook County, Illinois on this
19 15th Day of March, A.D., 2018.

20
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able 29:2 abnormal 27:4 31:19 abnormalities 36:7 Absolutely 5:12 17:6 accident 14:6 15:6 29:16 35:5 37:4,9 37:11,19 38:3,10 38:17 accomplish 7:10 accurate 40:12 acting 40:10 active 15:7,7 37:22 38:2 activity 13:24 actual 9:20,21 acute 8:20 17:16,19 addition 36:3 adults 7:7 adverse 8:12 afternoon 4:8 32:12,18 aging 7:8 ago 12:21 Agree 19:21 agreed 37:9 al 1:7 AMG 10:13 amount 7:9 21:2 anemia 36:7 answer 4:18 5:5,15 14:8 18:16 23:17 30:19,21 31:2 answered 37:20 answering 4:20 5:10 38:10 answers 4:24 5:3 40:9,13 antidepressant 22:17 anti-anxiety 22:17 anxiety 22:8 27:22 29:8 30:23 31:1	anybody 20:22 23:18 24:17 anymore 21:14 Anyway 10:17 apparatus 22:6 apparently 27:1 appeared 37:23 appears 13:20 14:5 16:24 27:10 28:12 appointment 26:5 27:18 approximate 8:5 April 24:21 26:7,9 26:19,20 27:7,10 29:8 37:5 39:5 area 6:22 arose 38:3 arousal 18:12 ashamed 23:12,20 asked 4:21 36:24 40:12 asking 10:20 aspects 20:19 assessment 38:19 associate 34:15 associated 6:12 7:8 18:5 30:20 35:5 36:11 37:4 ASSOCIATES 2:2 assume 5:6 attending 6:11 attendings 7:13 attention 33:12 attorney 9:2 32:15 attribute 15:17 30:17 attributed 30:22 audible 4:24 August 13:20 14:6 14:6 15:4,18,21 16:12,13 27:11 37:12 38:11 authenticate 14:18 aware 31:1 A.D 40:6,19	B 3:7 back 7:21 20:4 21:7 21:15,24 23:24 24:18 29:1,2,7 30:4 32:12 34:11 34:11,11 background 6:1 Ballard 1:16 40:4 based 15:13,14 24:16 basic 26:4 basically 7:7 9:14 9:17 27:2 bearing 4:9 beats 18:14 beginning 13:16 30:5 38:12 begins 16:7 behalf 2:6,11 4:3 believe 10:15 15:19 18:24 19:5 23:9 27:22 34:17,21 37:14 benign 19:20 22:3,5 22:6 28:8 34:1 best 9:14 better 29:2 BID 22:13,14,15 bit 26:14 BLACKWELL 2:8 blanket 18:10 blood 19:23 26:4,10 26:13,14 board 6:20 bottom 19:14 Boulevard 2:3 bouts 33:7,11 BPPV 22:3 34:15 break 5:8,11 32:8 breast 15:9 briefly 8:9 bring 21:7 bully 18:20 21:17 bullying 21:19	bunch 31:19 Bupropion 19:22 21:6 Bupropion 22:12 22:17,22 24:22 business 13:24 14:20,21 C C 2:1 called 4:3 16:16 Calls 23:14 38:7 capacity 7:15 car 14:5 29:16 35:5 37:4,9,11,19 38:3 38:9,17 cardiovascular 15:23 16:3,3,19 16:20 care 6:4 7:10,16 8:12 11:14 17:17 17:18 caring 23:12 case 8:14 11:24 16:24 33:4 40:16 cause 15:18 23:2,7 25:1 30:18 31:16 31:22 caused 30:23 causing 31:17 CBC 12:19 center 1:6 6:14 40:22 certain 22:5 certainly 13:13 14:5 CERTIFICATE 40:1 certified 1:14 6:20 challenges 4:9 change 38:19 chart 27:9 chest 8:18 Chicago 2:4,9 chronic 7:8 17:18 chronologically	25:8 circumstances 5:14 City 40:5 Civil 1:11 claim 8:11 claims 8:10 clarify 8:24 30:3 36:20 class 18:21 19:3 20:23 21:17,21 classically 34:9 cleared 20:4 clinical 9:14,16,19 21:1 23:13 25:11 25:15 27:17 28:23 29:5,21 clinically 23:19 closely 12:4 closer 39:4 Code 1:11 colleagues 11:10 come 16:2 28:14 29:7 33:12 38:4 comes 11:11 34:20 comments 19:7 common 18:4 complain 16:22 29:11,14 complained 34:18 37:1 38:21 complaining 8:18 15:5 17:9 38:23 39:1 complaints 17:13 19:15 35:2 complete 5:3 23:21 27:9 completely 10:14 concern 37:2 concerning 29:4 condition 35:24 38:4,6 conducted 13:24 31:5 confirm 36:24 Conley 13:21 14:13

connection 28:10 36:4 conscious 18:14 considered 15:23 consist 33:23 consistent 33:9 consistently 32:22 33:1 consists 29:21 34:2 constitute 14:20 contain 14:21 content 37:16 context 7:17 contractions 18:4 contributing 36:3 Cook 40:5,18 corner 12:9 correct 10:1,23,24 13:5 17:14,24 20:13 21:12 23:5 23:6 26:24 29:5,6 31:6 32:23,24 33:3,14,18 35:24 37:6,24 38:1,14 39:6 40:11 correctly 33:19 counsel 5:22 14:17 40:16 count 26:4 counts 26:15 County 40:5,18 couple 32:5 38:16 course 9:24 13:24 16:4 35:9 Court 1:1,12 39:8 39:11 Courtheoux 2:8 3:4 3:6 4:7 14:17,23 23:16 28:19 32:2 32:7 36:20,23 38:8 39:7,9 created 12:24 14:3 CSR 2:13 40:4,20 40:21 C.S.R 1:24	<div style="text-align: center;">D</div> D 3:1 daily 22:12 Daniel 16:12 date 12:22 dates 8:5 day 16:23 20:7 21:9 22:15 24:23,23 27:2 30:15 31:5 31:10 40:19 days 14:7 15:6 Deanna 1:14,24 2:13 40:3,20 Decker 12:19 13:11 Defendant 4:3 Defendants 1:8 2:11 9:1 degree 21:4 Dennis 36:12,13,17 depending 12:1 depends 16:5 18:16 deposition 1:10 3:10 4:11,17 8:24 depositions 1:13 7:21,22 depressed 19:18 23:5,11,19,22 depression 21:6 23:8 describe 7:4 8:10 19:11 detail 27:23 determined 8:18 diabetes 7:9 diagnose 7:7 34:1 diagnoses 30:12 diagnosis 30:14,16 38:13 dicks 19:18 33:20 33:22,24 34:12 difficult 5:15 13:12 difficulty 11:1 direction 27:12 34:3,10 discipline 7:1	discovery 1:14 discuss 11:24 discussed 15:19 19:15 23:4 26:6 27:22 discussing 12:5 disease 36:6 diseases 7:6 dismissed 8:22 disorder 19:21 disorders 22:5 distraught 24:9 distress 24:10 DISTRICT 1:1,1 disturbing 19:21 DIVISION 1:2 dizziness 19:16 23:2 28:7,9 29:3,8 36:14 Doctor 14:24 32:12 36:24 document 13:16,19 14:3 16:10,11 17:7,8 24:1 25:10 25:11,24 26:18 27:16 30:9 documents 3:10 5:19 9:4,7,8,11 11:3 12:8 14:16 25:14 29:19,22 doing 21:7 Dr 4:11 8:23 13:11 13:21 14:12 16:12 17:10 21:19 24:4 25:5 26:5 27:18 27:18 29:10,19 32:3 36:12,13,17 38:9 drawn 26:10 Drive 10:14 drug 23:1 duly 4:4 40:7 duties 28:24 <div style="text-align: center;">E</div> E 2:1,1 3:1,7	ear 19:21 36:13 earlier 24:1 EASTERN 1:2 echo 19:23 echocardiogram 25:2 26:1,3,24 27:2 educational 6:1 28:23 effect 22:23 effects 22:19,21 effusion 27:5 either 11:19 ekbsiegel@aol.com 2:5 Elaine 2:2,3 32:15 electrolyte 36:6 electronic 13:3 eluded 23:24 employment 6:9 EMR 13:2 et 1:7 evaluate 10:11 event 14:4 exactly 10:22 12:13 21:8 exam 19:18 31:10 Examination 3:4,5 3:6 4:6 32:10 36:22 examined 4:4 40:8 Excellent 5:21 excess 23:2 excuse 13:15 20:3 24:12 excused 24:6 exhibits 5:19 expect 31:20 experience 18:8 20:7 experienced 35:15 37:5,10 experiencing 31:2 35:9 36:4 expert 7:24 explain 9:11 22:1 22:11 25:13 33:22 34:7 explaining 39:9 explore 21:14 36:2 eye 34:8,10 <div style="text-align: center;">F</div> facility 10:15 factors 32:1 36:3 failing 20:18 fair 5:11 7:9 13:7 15:20 21:8,10 33:4,7 35:12 fairly 33:9 familiar 4:16 family 10:9 far 33:9 feel 5:8 23:22 feeling 19:9 20:11 feels 19:17 felt 19:1 21:12 23:12,20 fewer 22:19 Finally 5:13 financially 21:3 find 11:17 29:22 31:21 finish 4:18 5:9 first 4:4,16 8:7,11 10:6 12:4 30:5 40:7 FLOOR 40:22 following 19:24 20:1,1 27:2 28:5 follows 4:5 follow-up 17:18 19:22,22 32:6,17 foregoing 40:2,11 form 27:18 forth 34:11 foundation 14:16 four 6:13 frame 33:10 frequently 16:1 22:18 35:23 front 9:8 25:6
---	---	--	--

full 4:19 5:3 further 3:6 36:19 36:22 <hr/> G G 1:10 3:3 4:2 40:3 40:13 general 6:15 7:6 generally 26:11 generate 34:4 gentleman 8:17 gestures 5:1 getting 7:11 19:2 give 8:5 31:17 given 5:21 7:22 19:24 24:22 25:16 go 4:14 11:2,3 14:17 25:7,9 28:4 30:4 32:12 goal 11:13 going 10:12 14:15 16:8 20:22 21:15 23:9,14 24:16 27:11 30:2 33:19 good 4:8 24:10 31:20 32:12 gotten 28:7 graduated 6:2,9 great 4:14 11:6 ground 4:16 guess 7:23 13:10 37:15 guidance 24:5 gynecologist 16:11 16:15 <hr/> H H 3:7 hallpike 19:19 33:20,23,24 34:12 handful 32:17 happened 29:23 happy 11:7 head 34:3 heading 17:20 30:12	health 31:21 hear 5:1 28:14 heard 4:19 heart 25:4 help 12:14 27:13 28:3 hereinabove 40:14 high 26:14 35:9 history 6:9,24 15:10,11 17:1,22 17:24 18:3,7 22:24 hocus-pocus 24:15 Holmes 1:10 3:3 4:2,11 8:23 21:19 25:5 29:10,19 32:3 38:9 40:3,13 home 8:19 honestly 20:8 Hospital 6:12 HPI 17:20,21 18:18 HUSCH 2:8 hypertension 7:9 <hr/> I ICU 20:22 ID 3:9 identification 34:14 identified 9:12 15:10 IL 2:4 Illinois 1:1,12,15 1:16 2:9 6:18 40:5 40:18 illness 17:22 imagine 23:18 implement 12:2 importantly 34:5 impressions 19:8 incident 29:15 included 19:23 26:24 includes 25:17 including 10:9 increased 22:13 24:23	independent 13:8 13:14 indication 34:5,13 induces 34:12 infection 8:13 initially 6:11 injury 24:18 29:14 inner 19:21 insight 21:22 31:17 intensive 7:16 interact 11:16 12:4 interacted 7:18 11:5 29:23 interested 40:15 intermittent 33:5,8 internal 6:4,7,23 7:6 10:10 35:17 interrogatories 40:8 involved 9:13 issue 21:14 23:10 issued 9:1,1 24:4 issues 15:16 25:2 items 14:19 <hr/> J Jackson 2:3 joined 6:14 judge 24:16 jump 25:7 <hr/> K KAREN 2:8 kept 13:23 14:9 kicked 9:20 Kimberly 17:10 kin 40:16 kind 24:15,18 31:21 36:6 King 10:14 know 4:19,20 5:8 7:14 9:6 10:3,12 13:1 15:11 18:10 20:16,23 21:8,20 21:20,22 24:15 27:12 29:12,15	30:6 31:3,10 33:9 33:10 knowledge 29:9 K.B 2:2,3 <hr/> L L 1:14,24 2:8,13 40:4,20 lab 12:19,22 13:4,8 13:14 26:23 31:8 31:15 labs 13:2,12 26:2,3 26:19,20 31:5,13 31:19 36:5 lack 14:15 31:24 lady 31:20 Lakeside 6:12 language 25:20 lawsuits 8:6 leave 25:17 led 38:3 LEGAL 1:21 40:21 letter 24:2 28:20,21 28:22 let's 7:21 21:24 23:24 32:8 37:2 level 12:1 levels 35:9 license 2:13 7:1 licensed 6:17 life 31:3 lightheaded 20:2 lightheadedness 17:9,14 23:2 28:6 29:3 listen 37:8 literal 12:15 little 26:13 LLP 2:8 locate 10:17 locating 11:1 long 12:20 longer 24:14 look 16:8 17:20 27:21 28:2 30:2 37:15	looked 29:21 38:12 looks 26:9 27:22 28:13 lot 10:11 18:11,13 18:19,20 19:16 21:16 36:14 lowers 22:23 lower-right 12:9 Luther 10:14 Lutheran 6:15 7:17 lying 34:2 <hr/> M MAGNA 1:21 40:21 main 23:10 malinger 34:18 34:22 maneuver 33:20,23 33:24 34:12 March 1:17 40:6,19 Marcial 1:3 7:14 9:15,23 32:16,19 33:16 34:18,21 35:2,8 36:2,16 Marcial's 33:4 Maricel 1:3 10:1,3 11:5,9 13:9 15:17 16:13,22 17:23 20:6,11 21:19 23:5,11,20 24:2,6 24:20 27:20 28:11 29:7,11,14,23 30:17 32:16 37:1 37:10 38:3,21 Maricel's 11:15 14:13 15:3,11 19:8 23:7 27:7 37:12 Mark 13:21 marked 3:8,10 10:18 MARKET 40:22 Martin 10:13 mass 15:9 matter 16:4 32:16
--	---	--	--	--

matters 14:21	37:18	nystagmus 19:18	25:6 37:13 38:12	PENN 40:22
mean 11:21 13:13	M.D 1:10 3:3 4:2	34:5,7,8,13	page 3:2 5:23 12:9	people 7:10 18:15
14:17 16:22 17:16	40:3,13		12:11,14,15,16	21:21 22:18,24
18:2 31:16 35:17		O	13:1,17 14:24	performed 23:21
meaning 27:6	N	object 14:15 23:14	15:1 16:8,8,16	33:15
means 12:12 13:1	N 2:1 3:1	Objection 38:7	17:5,16 19:14,24	performing 20:15
17:18 18:3 19:19	name 10:10 32:15	objective 34:13,14	20:1,1 21:15,23	pericardial 27:5
22:15	named 36:12	obtained 27:1	23:24 25:6,9,21	period 24:14 29:10
meant 5:6	nature 7:4	obvious 4:23	26:16 27:13 28:2	29:13 32:20 37:3
medical 1:6 6:2,9	nausea 28:7	occasion 9:24 10:8	28:20,20 30:5,9	periodically 32:20
6:14 7:4,8 13:3	near 7:23 14:3	October 30:15 39:4	30:10 37:22,24	periods 35:1 37:1
14:8 17:23 18:3,7	neck 15:5 39:1	office 8:18 9:8	38:12,13	37:10 38:20 39:3
medically 20:4	need 5:8 12:3 24:17	11:11,17 13:8,10	pain 8:18 29:11	39:4
medication 22:16	24:17	16:13,15 20:1	39:1	peripheral 34:14
22:18 23:3	needed 19:2 37:14	29:19,24	palpitation 19:16	permanent 8:13
medications 5:13	negative 36:9	official 40:17	37:2	personally 10:7
22:20	negotiation 24:18	okay 4:21 5:1,2,6,7	palpitations 15:10	11:18
medicine 6:4,7,18	non-cardiac 8:19	8:23 9:3,22 11:2	15:12,16,17,19,20	pertaining 1:13
6:23 7:6 10:10	non-fasting 26:14	12:7,17 13:18	15:23 16:23 17:2	Pesch 16:12
35:17	normal 19:18 26:13	16:9 17:6,7 21:23	17:9,14 18:6,8,12	PHILADELPHIA
mentioned 7:22	26:15,22 27:3,6	25:10,23 26:16,17	20:2 25:3 30:16	40:23
met 7:14,17	28:23 31:9,14,15	27:15 28:15 30:3	30:17,24 31:16,22	physical 29:14
metabolic 24:24	31:19 36:10	31:15 32:2	33:2,5 34:20,23	31:10,24
26:4	NORTHERN 1:1	older 8:17	35:3,13,23 37:2,3	physician 6:11
MI 8:20	Northwestern 6:2,3	once 7:20 10:22	37:10,17,23 38:14	17:12 36:14
middle 30:10 37:24	6:13	24:22	38:21,24 39:2,3	place 40:14
milligrams 22:12	nose 36:13	ongoing 38:5,6	panels 26:4	Plaintiff 1:4 2:6
mind 5:24 6:8	Notary 40:4,10,17	opportunity 20:24	Park 1:16 40:5	5:22 32:16
18:17,24 25:5	note 9:20 10:16	oral 40:8	paroxysmal 22:4,6	Plaintiff's 5:22
27:13 37:19 39:9	11:19 13:20 14:13	order 5:23 12:13	28:8 34:1	plan 11:24 19:21
minute 30:2 32:5	16:11 17:17 19:14	34:4	part 36:7	Plaza 2:9
minutes 4:14	19:23 24:12 25:12	ordered 10:11	particular 15:13,18	please 4:17,24 5:5,8
mistakes 23:12	27:21,24 30:20	12:19 24:24 26:5	30:18	5:24 11:4 13:16
misused 19:17	38:23	26:20 28:10	parties 40:16	14:24 16:7 17:4
21:13	noted 15:8 19:22	ordering 12:5	partner 13:22	20:3 22:1 25:6,21
moment 11:1 13:15	23:4 37:23 38:13	oriented 23:19	pass 10:3	26:16 34:7 36:21
month 7:20	notes 9:19,21 10:8	outcome 8:12	passed 8:20	pneumococcal 8:13
Moore 36:12,13,17	10:12 14:12 29:21	overall 23:3	patient 7:15,19	point 10:21 11:4
motor 15:6	30:3,5 33:15	oversee 11:18	8:11 10:21 11:10	poorly 20:15
movement 34:8	37:12	o'clock 40:6	11:23 17:8 18:8	positional 22:6
movements 34:1	notice 12:8 18:16		18:13,19,20 19:1	28:8 34:2
moves 34:10	number 3:9 12:14	P	19:15 20:3 21:16	possible 11:14
multifactorial	24:23 31:24	P 2:1,1	24:19 25:16 34:2	13:13
31:23 35:20,22,24	numbered 5:23	PA 40:23	patients 11:14 16:2	practice 6:14,17
multi-year 32:20	numbers 12:9,11	packet 3:10 5:18,21	23:13	7:5,6,12 8:4 9:24
musculoskeletal	nurse 7:16 21:1	15:1 16:7 17:4	patient's 18:16	10:4,9,13 11:9,13

<p>14:1,9,14 36:12 practicing 6:4 practitioner 21:1 36:11 practitioners 35:18 precipitate 35:12 predated 15:20 premature 18:4,14 prepared 25:12 prescribed 24:20 present 17:22 32:23 33:1 presented 13:2 17:8 presents 11:24 pretty 20:9 23:3 prevent 7:10 preventative 7:10 previous 28:6 38:4 38:6 previously 21:24 26:6 primary 6:4 printed 9:21 prior 15:6 probably 13:10 19:20 22:22 26:9 28:8 38:22 39:6 problem 17:19 18:4 32:7 38:3 problems 7:7,8 15:7,8 37:22 38:2 Procedure 1:11 proceeding 12:12 produced 9:9,12 29:20 professional 6:24 program 6:15 20:18 pronounce 33:19 provide 5:3 9:4 providers 7:12 14:14 29:24 provisions 1:11 psychological 32:1 Public 40:4,10,18</p>	<p>purpose 1:13 27:20 27:24 pursuant 1:11 9:1,4 pursue 20:19 21:3 PVC 17:24 PVCs 18:7 p.m 1:17 40:6</p> <hr/> <p style="text-align: center;">Q</p> <p>question 4:18,19,20 5:5,5,10 14:10 20:16 28:15,16 30:19,21 31:3 37:8 38:11 39:10 questioning 30:4 questions 5:4,15 32:6,17 37:20 40:9,12 quickly 34:3</p> <hr/> <p style="text-align: center;">R</p> <p>R 2:1 rapid 34:8,11 rapidly 34:10 read 10:18,19 21:16 28:16 ready 32:12 really 12:3 23:1 27:9,24 31:2 37:17 reason 15:3 16:2 17:13 34:17,21 reasons 25:17 recall 15:16 19:3 36:16 received 5:23 recess 32:9 recognize 9:10 12:18 13:19 recollection 10:20 15:14 recommend 21:5 recommended 29:4 record 12:18,24 13:3,23 15:8,13 32:13 33:22 36:21</p>	<p>40:12 records 14:4,9,11 14:16,20,22 31:13 referred 3:10 19:7 21:23 36:16 37:11 40:14 referring 29:18 37:5,11,15 38:10 reflect 18:23,24 26:22 33:15 reflected 37:13 reflections 29:23 regards 14:9 regularly 13:24 related 18:12 25:3 28:8 29:22 31:23 31:24 relating 19:20 relationship 11:15 25:13,15 relaying 19:9 reliable 29:22 relying 12:11 remain 29:4 remember 20:8 29:16 report 26:1 reported 1:20 2:13 35:8 Reporter 1:15 39:8 39:11 REPORTER'S 40:1 reprimand 7:1 request 24:6 reserve 39:11,13 residency 6:3,6,10 6:15 11:12 23:22 resident 11:19,23 12:20 residents 7:13 10:9 10:10,16 11:14 12:3 17:11 resident's 12:1 resolution 8:14 resolved 4:10 8:21</p>	<p>response 29:20 rest 13:12 result 26:19 results 12:5 13:4 26:11,22 31:8 return 20:4 28:23 29:2 review 4:15 16:18 reviewed 25:12 reviewing 6:8 Ridge 1:16 40:5 right 10:17 25:9 26:1 28:4 32:20 33:2,13,16 34:6 35:3,6,10,21 36:9 38:20 risk 20:18 Riverside 2:9 Road 1:16 40:4 ROS 16:16 routine 11:9,12 rules 1:12 4:16 run 11:12 26:7 28:10 RUSH 1:6</p> <hr/> <p style="text-align: center;">S</p> <p>S 2:1 3:7 saccade 34:9 saw 10:15 11:20 29:1 32:19 saying 14:19 says 17:16,20,23 19:14 22:8,12 28:20 30:12 school 6:2,10 18:20 19:5,17,24 20:3,5 20:7,15,23 21:11 23:9 24:3,7 28:22 29:5 37:5 scope 14:21 seal 40:17 second 8:7,16,17 12:2 15:1 22:4 section 16:16 see 10:6 11:10 14:6</p>	<p>21:7 22:5 23:4 24:24 25:2,13 26:22 31:12 37:15 37:16 38:22 seeing 13:12 17:10 seen 10:7,21 19:14 20:1 28:24 35:15 35:17,18 sees 11:23 seizures 22:23,24 22:24 sensation 18:5,11 sent 8:19 9:7 36:5 separate 9:5 10:14 sequence 12:13 series 33:24 serious 22:22 SERVICES 1:21 40:21 set 4:23 13:4 30:5 setting 23:13 settled 8:15 SEVEN 40:22 Sharon 12:19 sheet 12:19 short 32:8,9 shortened 27:18 shorter 24:14 shorthand 1:15 40:9 shoulder 15:5 39:1 sick 7:11 side 10:13 22:19,21 22:22 Siegel 2:2,3 3:5 14:15,19 23:14 32:5,8,11,15 36:19,24 38:7,20 Siegel's 37:8,20 38:11 signature 39:8,12 39:13 40:17 significant 27:6 signs 25:18 similar 14:13 sitting 32:18</p>
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situation 16:5 19:6 20:24 skill 12:1 sleep 31:24 slowly 34:11 small 32:17 somebody 18:13 soreness 15:6 sorry 25:7 27:19 28:13 sort 12:5 24:11 25:19 36:7 sought 10:4 sounds 10:21 source 24:10 sources 10:9 south 2:9 10:13,13 speak 4:24 5:1 speaking 26:12 specialization 6:6 specifically 38:13 speculation 23:15 38:7 spend 7:9 spent 6:13 spoke 19:11 33:10 34:22 spoken 34:16 stacked 12:13 stand 16:17 stands 22:3 start 9:22 12:16 started 5:24 21:5 starting 37:13 starts 17:4 state 1:12,15 6:18 8:13 18:12,17,24 statement 18:11,18 21:15 40:2 statements 18:23 states 1:1 18:19,20 21:16 28:6 stating 28:22 stay 12:14 stenographer 40:10 STREET 40:22	stress 18:13,15 19:16 20:20 21:3 21:4 30:23 31:1 31:23 35:9,12 36:3 37:5 stressed 18:19 20:12,14,17,21 21:9 stressful 20:24 student 21:2 studies 35:10 36:4 subjective 19:8 subpoena 9:1,5 29:20 subsequently 8:19 9:18 successfully 23:21 suffered 8:12 suffering 34:22 36:6 sugar 26:13 suggest 38:2,4 Suite 2:3,9 suits 8:3 summaries 9:15,17 29:21 summary 9:19 25:11,16,19 27:17 supervise 11:20,21 supervising 17:12 supplement 28:1 support 19:2 Supreme 1:12 sure 6:11 10:17,22 31:12 36:5 suspension 7:1 sworn 4:1,4 40:7 symptoms 15:24 16:3,4,19,20 19:19 25:1 29:1 system 34:6 systems 16:18 S-A-C-C-A-D-E 34:9	T 3:7 table 5:10 34:3 take 5:9,10 20:11 24:2,22 28:24 30:2 32:5,8 taken 1:10,14 4:11 4:17 20:9 40:3,9 talked 19:4 25:18 35:1 talking 21:20 teachers 21:21 teaching 6:14 21:1 tearful 19:5,17 23:5 23:11,19 24:9 tearfulness 23:7 technical 4:9 tell 15:3 17:1 24:17 27:10 30:14 test 13:14 26:5,11 26:14 testified 4:4 32:19 35:20 tests 12:5 19:23 24:24 26:7,15,23 28:10,12 31:8,15 33:15,18 thank 5:18 6:8,17 6:24 8:16,23 11:8 12:7 13:6,15 25:21 30:8 32:2 32:17 36:19 39:7 Thanks 4:8 9:22 therabout 38:11 thing 12:6 30:4 36:7,20 38:9 think 19:13 20:8 21:23 22:4 24:8 26:2 29:17,17 35:14 37:4,22 38:22 39:6 thinking 38:17 third 12:2 THOMAS 1:10 3:3 4:2 40:3,13 thought 34:9 threshold 22:23	throat 36:13 thyroid 26:4,15 36:6 time 7:9 10:15 12:4 12:20,20 14:4 17:11 19:15 20:23 21:4 24:16 28:2 31:4 32:22 33:10 38:5,24 40:14 times 11:16 35:21 time-wise 21:3 timing 38:20 today 5:16 20:2 29:21 35:1 told 19:12 28:24 tolerated 23:3 top 17:17 22:2 28:21 training 11:13 Tran 17:10 24:4 26:5 treat 7:7 9:24 treated 21:13 treating 15:14 treatment 9:23 11:15,18,24 24:20 29:7 tremendous 21:2 trial 19:22 trivial 27:5 true 35:11 40:11 try 10:11 22:12 33:20 34:4 trying 7:10 25:7 Tufano 1:14,24 2:13 40:4,20 turn 7:21 13:16 14:24 16:7 17:4 21:24 23:24 25:21 26:16 turning 25:5 27:13 30:9 34:3 twice 22:15 24:23 two 8:2,3,6 14:7 15:6 24:17 25:14 35:1 37:1 38:20	39:3,4 <hr/> U undersigned 40:10 40:15 understand 5:4,15 5:18 9:23 14:10 understood 5:6 unfairly 21:13 Unfortunately 12:12 unit 7:16 UNITED 1:1 UNIVERSITY 1:6 upset 19:1,5 20:10 24:8 use 5:19 22:18 34:1 usually 31:21,22 34:8,15 35:22 39:13 <hr/> V VA 6:12,12 variety 10:8 various 25:17 vegetative 8:13 vehicle 15:6 ventricular 18:4 vertigo 22:2,3,5,7,9 28:9 29:8 32:23 33:7,11,16 34:2,4 34:13,15,18 35:2 36:15 37:2,16 38:24 vestibular 22:6 34:6 videoconference 2:2,8 visit 10:16 11:20,21 13:8,9,11 14:12 15:3,21 16:13 17:13,19 19:4,15 25:19 27:7,20 28:5,11 37:12 visited 15:18 visits 9:15 11:11
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14:13			
vital 25:18	X	2006 8:8	60604 2:4
vs 1:5	X 3:1,7	2007 12:21 30:15	60606 2:9
		30:17,24 38:16	624-6221 1:22
	Y	39:4	40:23
W	yeah 26:10 38:22	2008 16:12,14	655-1500 2:10
waive 39:12	year 12:2	2009 13:20 15:4,18	8
walk 11:4	years 6:13 12:4	15:21 37:12 38:11	8 7:13
walking 6:1 9:22	38:16	38:23	8TH 40:22
want 8:8	young 22:18 31:20	2012 27:11 29:10	866 1:22 40:23
wanted 4:15		29:13	87 13:17 37:13,14
wasn't 36:5	Z	2014 24:21 26:8,19	88 14:24 37:22
way 4:19 14:8	Zang 27:18	26:20 27:8 29:8	
week 20:3 22:13	Zong 27:19	37:5 39:5	9
24:13,23 28:6,24		2015 29:10,13	9th 14:6
29:1,1	0	2018 1:17 40:6,19	92 16:8
weeks 21:7 24:17	084-003819 2:13	2200 2:9	94 16:8,16
welcome 32:4	40:21	2545 10:13	97 12:16 30:5 38:12
well-tolerated 23:1	1	29 30:15	99 30:10 38:13
went 13:11 19:4	1:00 1:17 40:5	3	
26:9	10 27:11	3 26:7 27:7	
West 2:3	10/29/2007 12:23	3rd 26:9	
we'll 4:20 12:11	11 13:20 15:4,18,21	312 2:4,10	
we're 16:8	37:12 38:11	32 3:5	
we've 29:20	11th 14:6	35 28:2	
witness 3:2 4:1,3	12 1:17	36 3:6 28:20	
7:24 28:17 39:13	12th 40:6		
40:3,7,13,17	120 2:9	4	
wondering 14:11	13 27:14	4 3:4	
word 22:2 37:23	15th 40:19	4/11/2014 27:19	
words 5:1 27:17	150 22:12	4/2/2014 17:10	
work 12:22 24:12	16 25:6,9	40 26:16	
29:2,5 36:14	16-CV-06109 1:5	405 2:3	
working 20:22 34:6	1635 40:22	45 25:22	
workup 13:13 20:2	1775 1:16 40:4	49 17:5	
36:8	18 8:1		
worse 28:7	19103 40:23	5	
worsening 28:9	1984 6:5	50 23:24	
wouldn't 25:5		51 17:16 21:15	
wrap 30:4	2	5106 1:5	
written 13:21 22:1	2 24:21 26:19,20	53 2:3	
22:11	2D 19:23	54 7:13 19:14 21:23	
wrong 27:11	2nd 27:11	583-9970 2:4	
wrote 10:16 19:13	20 7:23		
20:8	2000 8:7	6	
www.magnals.com	2005 8:8	6 16:12,14	
1:23			

EXHIBIT

A24

AO 88B (Rev. 06/99) Subpoena to Produce Documents, Information, or Objects or to Permit Inspection of Premises in a Civil Action

UNITED STATES DISTRICT COURT

for the

Northern District of Illinois

MARICEL MARCIAL

Plaintiff

v.

RUSH UNIVERSITY MEDICAL CENTER, ET AL.,

Defendant

Civil Action No. 16-CV-06109

(If the action is pending in another district, state where:

SUBPOENA TO PRODUCE DOCUMENTS, INFORMATION, OR OBJECTS
OR TO PERMIT INSPECTION OF PREMISES IN A CIVIL ACTIONTo: Thomas Holmes, 1775 Bullard Road
Park Ridge, IL 60068

☒ **Production:** YOU ARE COMMANDED to produce at the time, date, and place set forth below the following documents, electronically stored information, or objects, and permit their inspection, copying, testing, or sampling of the material: See Attachment A

Place: Franczek Radelet, P.C.
300 S. Wacker Dr., Ste. 3400
Chicago, IL 60606

Date and Time:

11/16/2017 11:00 am

☐ **Inspection of Premises:** YOU ARE COMMANDED to permit entry onto the designated premises, land, or other property possessed or controlled by you at the time, date, and location set forth below, so that the requesting party may inspect, measure, survey, photograph, test, or sample the property or any designated object or operation on it.

Place:

Date and Time:

The provisions of Fed. R. Civ. P. 45(e), relating to your protection as a person subject to a subpoena, and Rule 45 (d) and (e), relating to your duty to respond to this subpoena and the potential consequences of not doing so, are attached.

Date: 11/01/2017

CLERK OF COURT

OR

Signature of Clerk or Deputy Clerk

s/Karen L. Courtheoux

Attorney's signature

The name, address, e-mail, and telephone number of the attorney representing (name of party) Rush University Medical Center, Dr. Michael Kremer, Ray Narbone and Jill Vilimberg, who issues or requests this subpoena, are:
Karen Courtheoux, Franczek Radelet P.C., 300 S. Wacker Dr., Ste. 3400, Chicago, IL 60606
Phone: 312-786-6687 Fax: 312-886-9192

AD-288 (Rev. 10/2013) Subpoena to Produce Documents, Information, or Objects or to Permit Inspection of Premises in a Civil Action (Page 2)

Civil Action No. 16-CV-08109

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 45.)

This subpoena for *(name of individual and title, if any)* _____
was received by me on *(date)* _____

☒ I served the subpoena by delivering a copy to the named person as follows: Thomas Holmes
1775 Ballard Road, Park Ridge, IL 60068
on *(date)* 11/01/2017 ; or

☐ I returned the subpoena unexecuted because: _____

Unless the subpoena was issued on behalf of the United States, or one of its officers or agents, I have also
tendered to the witness fees for one day's attendance, and the mileage allowed by law, in the amount of
\$ _____

My fees are \$ _____ for travel and \$ _____ for services, for a total of \$ 0.00

I declare under penalty of perjury that this information is true.

Date: 11/01/2017

s/Karen L. Courthoux
Server's signature

Karen L. Courthoux
Printed name and title
Franczuk Radelet P.C.
300 S. Wacker Drive, Suite 3400
Chicago, IL 60606

Server's address

Additional information regarding attempted service, etc:

FRCP 45 (Rev. 06/05) Subpoena to Produce Documents, Information, or Objects or to Permit Inspection of Premises in a Civil Action (Page 3)

Federal Rule of Civil Procedure 45 (c), (d), and (e) (Effective 12/1/07)

(c) Protecting a Person Subject to a Subpoena.

(1) *Avoiding Undue Burden or Expense; Sanctions.* A party or attorney responsible for issuing and serving a subpoena must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena. The issuing court must enforce this duty and impose an appropriate sanction — which may include lost earnings and reasonable attorney's fees — on a party or attorney who fails to comply.

(2) *Command to Produce Materials or Permit Inspection.*

(A) *Appearance Not Required.* A person commanded to produce documents, electronically stored information, or tangible things, or to permit the inspection of premises, need not appear in person at the place of production or inspection unless also commanded to appear for a deposition, hearing, or trial.

(B) *Objections.* A person commanded to produce documents or tangible things or to permit inspection may serve on the party or attorney designated in the subpoena a written objection to inspecting, copying, copying, testing or sampling any or all of the materials or to inspecting the premises — or to producing electronically stored information in the form or forms requested. The objection must be served before the earlier of the time specified for compliance or 14 days after the subpoena is served. If an objection is made, the following rules apply:

(i) At any time, on notice to the commanded person, the serving party may move the issuing court for an order compelling production or inspection.

(ii) These acts may be required only as directed in the order, and the order must protect a person who is neither a party nor a party's officer from significant expense resulting from compliance.

(3) *Quashing or Modifying a Subpoena.*

(A) *When Required.* On timely motion, the issuing court must quash or modify a subpoena that:

(i) fails to allow a reasonable time to comply;

(ii) requires a person who is neither a party nor a party's officer to travel more than 100 miles from where that person resides, is employed, or regularly conducts business in person — except that, subject to Rule 45(c)(3)(B)(iii), the person may be commanded to attend a trial by traveling from any such place within the state where the trial is held;

(iii) requires disclosure of privileged or other protected matter, if an exception or waiver applies; or

(iv) subjects a person to undue burden.

(B) *When Permitted.* To protect a person subject to or affected by a subpoena, the issuing court may, on motion, quash or modify the subpoena if it requires:

(i) disclosing a trade secret or other confidential research, development, or commercial information;

(ii) disclosing an uncertain expert's opinion or information that does not describe specific occurrences in dispute and results from the expert's study that was not requested by a party; or

(iii) a person who is neither a party nor a party's officer to incur substantial expense to travel more than 100 miles to attend trial.

(C) *Specifying Conditions as an Alternative.* In the circumstances described in Rule 45(c)(3)(B), the court may, instead of quashing or modifying a subpoena, order appearance or production under specified conditions if the serving party:

(i) shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship; and

(ii) ensures that the subpoenaed person will be reasonably compensated.

(d) Duties in Responding to a Subpoena.

(1) *Producing Documents or Electronically Stored Information.* These procedures apply to producing documents or electronically stored information:

(A) *Documents.* A person responding to a subpoena to produce documents must produce them as they are kept in the ordinary course of business or must organize and label them to correspond to the categories in the demand.

(B) *Form for Producing Electronically Stored Information Not Specified.* If a subpoena does not specify a form for producing electronically stored information, the person responding must produce it in a form or forms in which it is ordinarily maintained or in a reasonably usable form or forms.

(C) *Electronically Stored Information Produced in Only One Form.* The person responding need not produce the same electronically stored information in more than one form.

(D) *Inaccessible Electronically Stored Information.* The person responding need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the person responding must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(2)(C). The court may specify conditions for the discovery.

(2) *Claiming Privilege or Protection.*

(A) *Information Withheld.* A person withholding subpoenaed information under a claim that it is privileged or subject to protection as trial-preparation material must:

(i) expressly make the claim; and

(ii) describe the nature of the withheld documents, communications, or tangible things in a manner that, without revealing information itself privileged or protected, will enable the parties to assess the claim.

(B) *Information Produced.* If information produced in response to a subpoena is subject to a claim of privilege or of protection as trial-preparation material, the person making the claim may notify any party that received the information of the claim and the basis for it. After being notified, a party must promptly return, sequester, or destroy the specified information and any copies it has; must not use or disclose the information until the claim is resolved; must take reasonable steps to retrieve the information if the party disclosed it before being notified; and may promptly present the information to the court under seal for a determination of the claim. The person who produced the information must preserve the information until the claim is resolved.

(e) *Contempt.* The issuing court may hold in contempt a person who, having been served, fails without adequate excuse to obey the subpoena. A nonparty's failure to obey must be excused if the subpoena purports to require the nonparty to attend or produce in a place outside the limits of Rule 45(c)(3)(A)(iii).

ATTACHMENT A

Copies of all medical, health, hospital, mental health and insurance records pertaining to Maricel Marcial (DOB: January 21, 1973; SSN: 359-88-7272), including, but not limited to, all admission or intake forms; records of office visits; records of appointments, whether they were kept, cancelled, or postponed; consents; summaries; charts; physicians', psychologists', psychiatrists', nurses' or others' notes, including "personal notes"; order sheets; all x-ray films and reports; all lab requisitions and reports; electrocardiogram or related reports; protocols; prescription records; reports of all referrals and non-surgical procedures, any specimens generated as a result thereof; reports of therapy and treatments; any records regarding telephone communications, examinations, evaluations, treatments or hospitalization; and any and all records received by you from any other physician or medical or mental health professional.

2415081.1

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, Marisel Marciel, hereby authorize the following health care provider:

Name: Thomas Holmes
Address: 1775 Ballard Road
Park Ridge, IL 60068

to use and/or disclose to the law firm of Franczek Radelet P.C. certain medical information for use in a lawsuit entitled Marisel Marciel v. Rush University Medical Center et al., Case No. 16 cv 6189, filed in the United States District Court for the Northern District of Illinois, Eastern Division.

The medical information for which I am authorizing disclosure is: all medical, health, hospital, mental health and insurance records pertaining to me, Marisel Marciel. This authorization includes, but is not limited to, all admission or intake forms; records of office visits; consents; summaries; charts; physicians', psychologists', psychiatrists', nurses' or others' notes, including "personal notes"; order sheets; all x-ray films and reports; all lab requisitions and reports; protocols; prescription records; reports of all referrals and non-surgical procedures; any specimens generated as a result thereof; reports of therapy and treatments; and any records regarding telephone communications, examinations, evaluations, treatments or hospitalization. This authorization includes any and all records received by you from any other physician or medical or mental health professional. The authority shall extend to the right to inspect any original document in the event deemed necessary by the reviewer.

I authorize the above-described information to be disclosed to the law firm Franczek Radelet P.C., its employees, and its representatives, as well as other persons, organizations and/or entities directly connected with the above lawsuit, including but not limited to the court, court reporter(s), copy services and others. I understand that disclosure shall be limited to the minimum necessary amount of such information to accomplish the intended purpose(s) described in the preceding paragraphs.

I understand that I have the right to inspect and copy the information to be used or disclosed. I further understand that medical treatment, payment, enrollment or eligibility for benefits may not be withheld from me based on failure to sign this Authorization. I understand that the medical information used or disclosed pursuant to this authorization may be subject to limited re-disclosure by the recipient for purposes of the above captioned lawsuit only and will no longer be protected by the Privacy Policy of the physician or health care facility to whom this authorization is directed.

I understand that I retain the right to revoke this Authorization in writing at any time by delivery of a written notice to the health care provider identified above and that such revocation shall be effective for future uses and disclosures of my protected health information, but such revocation shall not be effective for information already used or disclosed. I understand that written revocation of this Authorization must be sent to the health care provider identified above.

This Authorization shall expire one year from the date signed below.

Marisel G. Marciel

Marisel Marciel

Social Security #: 359-88-7272

Address: 2616 N. SPANGLING AVE APT # 3
CHICAGO, IL 60647

Executed this 20th day of October, 2017

2301649.1

018

1107-01-01

1107-01-01

0477730002

Advocate Medical Group
 AMG-Sykes
 2545 S. Martin Luther King Drive
 Chicago, IL 60616
 (312) 842-7117

Clinical Summary-RTF
 12/15/2016 3:30PM

Patient:
 MARICEL MARCIAL
 2616 N SPAULDING APT 3
 CHICAGO, IL 60647
 MRN: 00341329
 DOB: 01/21/1973
 Phone: (847) 809-5669

Clinical Summary

Patient Details for MARCIAL, MARICEL Q.

MARICEL
Preferred Name

Female
Sex

00341329
MRN

2616 N SPAULDING, APT 3,
 CHICAGO, IL, 60647
Address

ENGLISH
Language

January 21, 1973
Born

Asian
Race

Non-Hispanic or Latino
Ethnicity

Today's Appointment

YOST, KYLE DO
Provider

15 Dec 2016 03:30 PM
Appointment

Reason for Visit

Health Issues Reviewed :

Heel pain
 Peroneal tendonitis

Current Health Issues

Anxiety
 Encounter for routine gynecological examination
 Encounter for screening for respiratory tuberculosis
 Fasting hyperglycemia
 Fibrocystic breast disease
 Heel pain
 Nonspecific reaction to tuberculin skin test without active tuberculosis

Printed By: Anita Powell

1 of 3

11/7/17 8:24:37 PM

Clinical Summary-RTF

Patient: MARICEL Q. MARCIAL
 Encounter: Dec 15 2016 3:30PM

SSN: XXX-XX-7272
 EMRN: 00341329

Palpitations
 Peroneal tendonitis
 Routine History And Physical
 Vertigo
 Visit for screening mammogram

Smoking Status

Never smoker

Medications**Current Medications:**

Medication	Instructions
Flonase Allergy Relief 50 MCG/ACT Nasal Suspension (Fluticasone Propionate)	
Zyrtec Allergy 10 MG Oral Capsule	

Allergies and Adverse Reactions

- No Known Drug Allergies

Vital Signs

Date/Time	12/15/2016 3:45:00 PM
Blood Pressure	105 / 64
Temperature	97.6 F
Heart Rate	73 bpm
Respiration	14
Height	5 ft 4.25 in
Weight	153 lb 6.00 oz
BMI Calculated	26.12 kg/m2
BSA Calculated	1.75 m2

Results

Results not documented.

Interventions**Follow-ups/Referrals:**

- DME/Orthotics/Prosthetics; To Be Done: 15 Dec 2016

Printed By: Anita Powell

2 of 3

11/7/17 8:24 38 PM

Clinical Summary-RTF

Patient: MARICEL Q. MARCIAL
 Encounter: Dec 15 2016 3:30PM

SSN: XXX-XX-7272
 EMRN: 00341329

Plan:

XR FOOT RT MIN 3V; Status:Complete; Done: 15Dec2016
 Perform:Other; Due:14Jan2017; Last Updated By:Brunner, Kristyn; 12/15/2016 4:43:27 PM;Ordered;
 For:Heel pain; Ordered By:YOST, KYLE;
 Annotations
 Right sides pain near calcaneus and 5th met. Possible fracture

Plan: <FNT>

<FNT>Xray reviewed by Dr. Skiba and I which showed a possible avulsion off the 5th met from a peroneal brevis injury. It is possible it is an accessory bone but with the irregularity of the base of the 5th met most likely an avulsion injury

Non Pneumatic CAM Walker ordered

Pt to WBAT in CAM Boot

Pt may work but may take off if pain too severe in boot

Tylenol for pain

F/U in 2 weeks or sooner if needed.

<FNT>Medical compliance with plan discussed and risks of non-compliance reviewed.\par

<FNT>Patient education completed on disease process, etiology & prognosis.\par

<FNT>Patient expresses understanding of the plan.\par

<FNT>Proper usage and side effects of medications reviewed & discussed.\par

<FNT>Refer to orders.\par

<FNT>Return to clinic as clinically indicated as discussed with patient who verbalized understanding of & agreement with the plan.

Document Details

AMG-Nesset
Site Name

(847) 318-2500
Phone

15 Dec 2016 07:18 PM
Created Date/Time

1775 Ballard Rd,Park
 Ridge,IL,60068
Site Address

(847) 318-2940
Fax

Elizabeth Malke
Printed By

Advocate Medical Group
AMG-Sykes
 2545 S. Martin Luther King Drive
 Chicago, IL 60616
 (312) 842-7117

Clinical Summary-RTF
 10/10/2016 2:15PM

Patient:
 MARICEL MARCIAL
 2616 N SPAULDING APT 3
 CHICAGO, IL 60647

MRN: 00341329
 DOB: 01/21/1973
 Phone: (847) 809-5669

Clinical Summary

Patient Details for MARCIAL, MARICEL Q.

MARICEL
Preferred Name

Female
Sex

00341329
MRN

2616 N SPAULDING, APT 3,
 CHICAGO, IL, 60647
Address

ENGLISH
Language

January 21, 1973
Born

Asian
Race

Non-Hispanic or Latino
Ethnicity

Today's Appointment

BURNOSKI, MELINDA MD
Provider

10 Oct 2016 02:15 PM
Appointment

Reason for Visit

Health Issues Reviewed :

Encounter for preventive health examination
 Fasting hyperglycemia
 Visit for screening mammogram

Current Health Issues

Anxiety
 Encounter for routine gynecological examination
 Encounter for screening for respiratory tuberculosis
 Fasting hyperglycemia
 Fibrocystic breast disease
 Nonspecific reaction to tuberculin skin test without active tuberculosis

Printed By: Anita Powell

1 of 3

11/7/17 8:24 41 PM

Clinical Summary-RTF

Patient: MARICEL Q. MARCIAL
 Encounter: Oct 10 2016 2:15PM

SSN: XXX-XX-7272
 EMRN: 00341329

Normal Routine History And Physical
 Palpitations
 Vertigo
 Visit for screening mammogram

Smoking Status

Never smoker

Medications**Current Medications:**

Medication	Instructions
Flonase Allergy Relief 50 MCG/ACT Nasal Suspension	
Zyrtec Allergy 10 MG Oral Capsule	

Allergies and Adverse Reactions

- No Known Drug Allergies

Vital Signs

Date/Time	10/10/2016 2:33:00 PM
Blood Pressure	107 / 73
Temperature	97.5 F
Heart Rate	75 bpm
Height	5 ft 4.25 in
Weight	154 lb
BMI Calculated	26.23 kg/m ²
BSA Calculated	1.76 m ²

Results

Results not documented.

Interventions**Labs/Procedure/Imaging:**

- BASIC METABOLIC PNL; To Be Done: 10 Oct 2016
- CBC WITH AUTOMATED DIFFERENTIAL; To Be Done: 10 Oct 2016
- HEMOGLOBIN A1C GLYCOSYLATED, To Be Done: 10 Oct 2016
- LIPID PNL, To Be Done: 10 Oct 2016

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2 of 3

11/7/17 8:24:42 PM

Clinical Summary-RTF

Patient: MARICEL Q. MARCIAL
Encounter: Oct 10 2016 2:15PM

SSN: XXX-XX-7272
EMRN: 00341329

- MA FFDM SCREEN BIL W TOMO W CAD; To Be Done: 10 Oct 2016
- VITAMIN D,25 HYDROXY; To Be Done: 10 Oct 2016

Follow-ups/Referrals:

- OB-GYN Referral/Consult; To Be Done: 10 Oct 2016

Document Details

AMG-Nesset
Site Name

(847) 318-2500
Phone

10 Oct 2016 04:33 PM
Created Date/Time

1775 Ballard Rd, Park
Ridge, IL, 60068
Site Address

(847) 318-2940
Fax

Lavon Beaudoin
Created By

Advocate Medical Group
AMG-Sykes
 2545 S. Martin Luther King Drive
 Chicago, IL 60616
 (312) 842-7117

Clinical Summary-RTF
 04/11/2014 1:30PM

Patient:
 MARICEL MARCIAL
 2616 N SPAULDING APT 3
 CHICAGO, IL 60647
 MRN: 00341329
 DOB: 01/21/1973
 Phone: (847) 809-5669

Clinical Summary

Patient Details for MARCIAL, MARICEL Q

MARICEL <i>Preferred Name</i>	Female <i>Sex</i>	00341329 <i>MRN</i>
2616 N SPAULDING APT 3, CHICAGO, 60647 <i>Address</i>	ENGLISH <i>Language</i>	January 21, 1973 <i>Born</i>
Asian <i>Race</i>	Non-Hispanic or Latino <i>Ethnicity</i>	

Today's Appointment

ZONG, KANGNI MD <i>Provider</i>	11 Apr 2014 01:30 PM <i>Appointment</i>
------------------------------------	--

Reason for Visit

Health Issues Reviewed :

- Vertigo

Current Health Issues

- Anxiety
- Encounter for routine gynecological examination
- Encounter for screening for respiratory tuberculosis
- Fibrocystic breast disease
- Nonspecific reaction to tuberculin skin test without active tuberculosis
- Normal Routine History And Physical
- Palpitations
- Vertigo

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1 of 3

11/7/17 8:24:45 PM

Clinical Summary-RTF

Patient: MARICEL Q. MARCIAL
 Encounter: Apr 11 2014 1:30PM

SSN: XXX-XX-7272
 EMRN: 00341329

Smoking Status

Never smoker

Medications**Current Medications:**

Medication	Instructions
Mechizine HCl - 25 MG Oral Tablet	TAKE 1 TABLET AT BEDTIME.

Allergies and Adverse Reactions

- No Known Drug Allergies

Vital Signs

Date/Time	04/11/2014 1:38:00 PM
Blood Pressure	80 / 50
Temperature	97.3 F
Heart Rate	68 bpm
Pulse Quality	Regular
Height	5 ft 4 in
Weight	148 lb
BMI Calculated	25.4 kg/m ²
BSA Calculated	1.72 m ²

Results

Results not documented.

Printed By: Anita Powell

2 of 3

11/7/17 8:24:46 PM

Clinical Summary-RTF

Patient: MARICEL Q. MARCIAL
Encounter: Apr 11 2014 1:30PM

SSN: XXX-XX-7272
EMRN: 00341329

Document Details

AMG-Nesset
Site Name

(847) 318-2500
Phone

11 Apr 2014 05:07 PM
Created Date/Time

1775 Ballard Rd. , Park Ridge, IL
60068
Site Address

(847) 318-2940
Fax

Lavon Beaudoin
Created By

Advocate Medical Group
AMG-Sykes
 2545 S. Martin Luther King Drive
 Chicago, IL 60616
 (312) 842-7117

Clinical Summary-RTF
 04/02/2014 3:15PM

Patient:
 MARICEL MARCIAL
 2616 N SPAULDING APT 3
 CHICAGO, IL 60647
 MRN: 00341329
 DOB: 01/21/1973
 Phone: (847) 809-5669

Clinical Summary

Patient Details for MARCIAL, MARICEL Q

MARICEL <i>Preferred Name</i>	Female <i>Sex</i>	00341329 <i>MRN</i>
2616 N SPAULDING, APT 3, CHICAGO, 60647 <i>Address</i>	ENGLISH <i>Language</i>	January 21, 1973 <i>Born</i>
Asian <i>Race</i>	Non-Hispanic or Latino <i>Ethnicity</i>	

Today's Appointment

TRAN, KIMBERLY DO <i>Provider</i>	02 Apr 2014 03:15 PM <i>Appointment</i>
--------------------------------------	--

Reason for Visit

Health Issues Reviewed :

- Anxiety
- Vertigo

Current Health Issues

- Anxiety
- Breast Fibrocystic Disease
- Normal Routine History And Physical
- Tuberculin PPD Induration Positive Interpretation
- Vertigo
- Visit For: Screening Exam Pulmonary Tuberculosis
- Visit For: Single System Exam Gynecological With Pap Smear

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1 of 4

11/7/17 8:24:49 PM

Clinical Summary-RTF

Patient: MARICEL Q. MARCIAL
 Encounter: Apr 2 2014 3:15PM

SSN: XXX-XX-7272
 EMRN: 00341329

Smoking Status

Never A Smoker

MedicationsCurrent Medications:

Medication	Instructions
BuPROPion HCl ER (SR) 150 MG Oral Tablet Extended Release 12 Hour	TAKE 1 TABLET DAILY FOR 1 WEEK, THEN TAKE 1 TABLET TWICE DAILY.

Allergies and Adverse Reactions

- No Known Drug Allergies

Vital Signs

Date/Time	04/02/2014 3:30:00 PM
Blood Pressure	100 / 70
Temperature	97 F
Heart Rate	72 bpm
Pulse Quality	Regular
Height	5 ft 4 in
Weight	145 lb 3.00 oz
BMI Calculated	24.92 kg/m ²
BSA Calculated	1.71 m ²

Results

Results not documented.

Printed By: Anita Powell

2 of 4

11/7/17 8:24 49 PM

Clinical Summary-RTF

Patient: MARICEL Q. MARCIAL
 Encounter: Apr 2 2014 3:15PM

SSN: XXX-XX-7272
 EMRN: 00341329

Treatment PlansFuture Appointment:

Provider	Date/Time	Location
NESSET, CARDIOVASCULAR TEST	03 Apr 2014 11:20 AM	NES
ECHO/ABI, NESSET	03 Apr 2014 11:20 AM	NES

InterventionsMedication Changes:

Medications	Update	Old Instructions	New Instructions
BuPROPion HCl ER (SR) 150 MG Oral Tablet Extended Release 12 Hour	Start	TAKE 1 TABLET DAILY FOR 1 WEEK, THEN TAKE 1 TABLET TWICE DAILY.	TAKE 1 TABLET DAILY FOR 1 WEEK, THEN TAKE 1 TABLET TWICE DAILY

Labs/Procedure/Imaging:

- CBC WITH AUTOMATED DIFFERENTIAL; To Be Done: 02 Apr 2014
- BASIC METABOLIC PNL; To Be Done: 02 Apr 2014
- TSH; To Be Done: 02 Apr 2014
- CD ECHO 2D COMPLETE W DOP AND COLOR-ADLT; To Be Done: 02 Apr 2014

Plan:

CBC WITH AUTOMATED DIFFERENTIAL; Requested for: 02 Apr 2014
 BASIC METABOLIC PNL; Requested for: 02 Apr 2014
 TSH; Requested for: 02 Apr 2014
 CD ECHO 2D COMPLETE W DOP AND COLOR-ADLT; Requested for: 02 Apr 2014
 BuPROPion HCl ER (SR) 150 MG Oral Tablet Extended Release 12 Hour; TAKE 1 TABLET DAILY FOR 1 WEEK, THEN TAKE 1 TABLET TWICE DAILY; Qty60; R0; Rx

Document Details

AMG-Nesset
 Site Name

(847) 318-2500
 Phone

02 Apr 2014 06:31 PM
 Created Date/Time

Printed By: Anita Powell

3 of 4

11/7/17 8:24:50 PM

Clinical Summary-RTF

Patient: MARICEL Q. MARCIAL
Encounter: Apr 2 2014 3:15PM

SSN: XXX-XX-7272
EMRN: 00341329

1775 Ballard Rd, , Park Ridge, IL (847) 318-2940
60068
Site Address Fax

Rebecca Whitford
Created By

Printed By: Anita Powell

4 of 4

11/7/17 8:24 51 PM

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date: 05Oct2017 1:30PM
Provider: DECHAMBRE, MARGAUX (12237)
Dept: Family Practice Nesset
Appt Loc: 1775 Ballard, family Prac Nesset
For:
Appt No.: 36195413
Pt Ins: HMO HUMANA/ADVOCATE
Special Billing:
CRF #:

Billing Provider: KOO, KEVIN
Compliance Code:
Performing Provider: DECHAMBRE, MARGAUX
Referring Provider:
Division: FAMILY PRACTICE
Location: FAMILY PRACTICE, NESSET 1775 BALLA
Billing Area: FAM PRAC NESSET 110
Special Billing Date:

Diagnoses

Primary	#	Code	Description
Yes	1	(M77.12)	Lateral epicondylitis of left elbow

Charges

Status	Units	Code	Mod	Description	Linked DX	Submitted by
Submitted	1	99213		Est Patient: Low Complexity	1	Whitman, Kathryn

Printed by: Powell, Anita

1

Date: 11/7/17 8:21PM

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

PCP Acute Care Note
10/05/2017 1:30PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

Reason For Visit

MARICEL MARCIAL is an established patient here today for a chief complaint of left elbow pain.
Translator: interpreter services not used.
A chaperone is not applicable. She is unaccompanied.

Quality

Adult Wellness CI height documented, discussion of regular exercise, exercising regularly, printed information given for activities, discussion of nutritional quality of diet, patient education given about proper diet, not using alcohol, no tobacco use, does not have feelings of hopelessness (PHQ-2) and no Anhedonia (PHQ-2).

History of Present Illness

Ms. Marcial is a 44yo F who presents to clinic today for left elbow pain that has been going on for two weeks.

#Left elbow pain for 2 weeks

- week 1, started to get better but then 3 days ago, she twisted left arm with fast internal rotation to grab phone and aggravated it suddenly again
- worse when she wakes up because she doesn't wear her left elbow brace at night
- pain has been steady and somewhat improving since 3 days ago
- works as an ICU nurse at LGH
- 9/21 - she had a strong patient; made patient go back into bed and left arm suffered a lot of backward force/resistance during the action; no initial pain then, just felt like lifted a lot of weights
- 9/22 kept having to pull patient up in bed and aggravated left elbow more
- using brace on left elbow to help with pain because gravity makes pain worse; has helped but not completely
- worse with grasping (pain down lateral elbow), twisting something open and pushing; lifting is okay; sharp, shooting pain, 8/10 with aggravating factors
- without aggravation, pain is 0/10 unless it's not in brace, then it's an achy pain when it feels the force of gravity
- tried ibuprofen q6h, but then had upset stomach; stopped yesterday afternoon; ibuprofen didn't help much
- has done ice compresses; a little help because it soothed and numbed
- applying more compression to area helps
- no tingling, no swelling, no bruising, no numbness; no fevers, chills or redness in area
- called off work to rest one day
- never had this pain before
- only exercise is running; has not used weights in several months
- thinks it might be tennis elbow

#Health maintenance - patient follows with internal medicine but came to us today because of the family medicine presence in sports medicine; would like to continue health maintenance with internal medicine.

Allergies

No Known Drug Allergies

Current Meds

Page 1 of 4 printed 11/07/2017 8:21PM

PCP Acute Care Note
10/05/2017 1:30PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

1. Flonase Allergy Relief 50 MCG/ACT Nasal Suspension;
Therapy: 10Oct2016 to Recorded
2. Zyrtec Allergy 10 MG Oral Capsule;
Therapy: 10Oct2016 to Recorded

Active Problems

Anxiety (F41.9)
Encounter for routine gynecological examination (Z01.419)
Encounter for screening for respiratory tuberculosis (Z11.1)
Fasting hyperglycemia (R73.01)
Fibrocystic breast disease (N60.19)
Heel pain (M79.673)
Neck Strain
 • post MVA
Nonspecific reaction to tuberculin skin test without active tuberculosis (R76.11)
Palpitations (R00.2)
Peroneal tendonitis (M76.70)
Routine History And Physical
Vertigo (R42)
Visit for screening mammogram (Z12.31)

Past Medical History

History of breast lump (Z87.898)

Surgical History

Denied: History Of Prior Surgery

Family History

Mother

Family history of Duct, Solid Type, Carcinoma In Situ Of The Breast
 • diagnosed at age 54

Paternal Aunt

Family history of Breast Cancer

Family History

Family history of Breast Cancer
Family history of Diabetes Mellitus

Social History

Denied: Alcohol
Denied: Considered Quitting Drinking Alcohol
Denied: Drinking Alcohol Regularly, Feeling Guilty About It
Denied: Drug Use
Exercising Regularly
Denied: Getting Angry When Talked To About Drinking
Denied: Having A Drink Or Two In The Morning To Get Going
Never smoker
Denied: Tobacco Use

Vitals

Vital Signs

Recorded: 05Oct2017 01:27PM

Height: 5 ft 4.25 in
Weight: 149 lb

PCP Acute Care Note
10/05/2017 1:30PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

BMI Calculated: 25.38
BSA Calculated: 1.73
Systolic: 110, RUE, Sitting
Diastolic: 60, RUE, Sitting
Temperature: 97.2 F, Temporal
Heart Rate: 67
O2 Saturation: 99

Physical Exam

Constitutional: alert, in no acute distress and current vital signs reviewed.
Head and Face: atraumatic, no deformities, normocephalic, normal facies.
Eyes: no discharge, normal conjunctiva, no eyelid swelling and the sclerae were normal. extraocular movements were intact.
ENT: no nasal discharge, normal lips, oral mucosa pink and moist.
Neck: normal appearing neck.
Pulmonary: no respiratory distress, normal respiratory rate and effort and no accessory muscle use. breath sounds clear to auscultation bilaterally.
Cardiovascular: normal rate, no murmurs were heard, regular rhythm, normal S1 and normal S2. edema was not present in the lower extremities.
Musculoskeletal: normal gait, all finger joints have full range of motion, no erythema of the fingers and no swelling of the fingers. no musculoskeletal erythema was seen and no joint swelling seen. 5/5 grip strength BL some pain elicited along left lateral elbow with attempted supination against resistance; no pain on right side normal strength without pain with elbow flexion and extension normal sensation to light touch BL upper extremities pinching using left digits causes some soreness around posterior forearm
Neurologic: cranial nerves grossly intact.
Psychiatric: oriented to person, oriented to place and oriented to time. alert and awake, interactive and mood/affect were appropriate. judgement not impaired and insight not impaired. normal attention span, logical and concrete. short term memory intact and long term memory intact
Skin, Hair, Nails: normal skin color and pigmentation and no rash.

Assessment

Lateral epicondylitis of left elbow (M77.12)
• Assessed By: DECHAMBRE, MARGAUX (Primary Care); Last Assessed: 05 Oct 2017

Discussion/Summary

Ms. Marcial is a 44yo F who presents to clinic today for left elbow pain that has been going on for two weeks with some improvement over the last three days.

#Lateral epicondylitis of the left elbow - symptoms are improving somewhat on their own
-naproxen 500mg PO BID PRN OTC for pain; advised patient to take this with meals and to stop if she continues to have stomach upset
-continue to wear left elbow brace and ice PRN for symptoms relief; rest left elbow as much as possible
-provided lateral epicondylitis exercises for patient to try at home
-f/u in two weeks if no improvement in symptoms; f/u sooner if symptoms worsen, do not continue to improve, any numbness, increase in pain, etc

#Health maintenance
-discussed that patient will need a pap smear, mammogram, most likely lab work this year
-patient stated that she will f/u with internal medicine for this
-patient will try to get flu vaccine at work without a charge

Patient seen by and discussed with Dr. Koo.

Margaux DeChambre, MD

PCP Acute Care Note
10/05/2017 1:30PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

Family Medicine PGY-1

Attending Note

I saw and evaluated the patient. I discussed the patient's case with the Resident. I agree with the Resident's findings and plan, as documented in today's note. koo

Signatures

Electronically signed by : Samantha Kaspar, CMA; Oct 5 2017 1:28PM CST
Electronically signed by : MARGAUX DECHAMBRE, M.D.; Oct 8 2017 8:36AM CST
Electronically signed by : MARGAUX DECHAMBRE, M.D.; Oct 8 2017 8:37AM CST
Electronically signed by : MARGAUX DECHAMBRE, M.D.; Oct 8 2017 8:38AM CST
Electronically signed by : KEVIN KOO, M.D.; Oct 12 2017 6:04PM CST

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # XR-16-0740848AMG
Ordering Provider: YOST, KYLE
Performing Location: AMG NESSET

Collected: 12/15/2016 4:37:00PM
Resulted: 12/15/2016 4:37:00PM
Verified By: YOST, KYLE
Auto Verify: N

XR FOOT RT MIN 3V

Stage: Final

Result 12/19/2016 9:14:00AM YOST, KYLE
Annotations: Questionable 5th met avulsion fx vs os vesalianium. Pt in short cam walker.

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
-------------	---------------	--------------	-----------------------------

XR FOOT RT MIN 3V

Accession #

XR-16-0740848

Clinical indication:

Healed pain.

AP and lateral views as well as oblique view of right foot were performed. There is moderate plantar calcaneal spur formation and small dorsal calcaneal spur formation.

Likely skin contamination overlying soft tissues of distal phalanx of 1st digit.

IMPRESSION:

Moderate plantar and small dorsal calcaneal spur formation, otherwise normal examination.

**** F I N A L ****

Transcribed By: TP
12/15/16 6:36 pm

Dictated By: DEVRIES-MD, MARIA

Electronically Reviewed and Approved By: DEVRIES-MD, MARIA 12/15/16 6:40 pm

Printed by: Powell, Anita | 11/07/2017 8:21:00PM

Page 1 of 1

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date 15Dec2016 3:30PM
Provider: YOST,KYLE (90140)
Dept: Family Practice Nessel
Appt Loc: 1775 Balland, family Prac Nessel
For:
Appt No.: 32730957
Pt Ins: HMO HUMANA/ADVOCATE
Special Billing:
CRF#:

Billing Provider: SKIBA, PHILIP
Compliance Code:
Performing Provider: YOST, KYLE
Referring Provider:
Division: FAMILY PRACTICE
Location: FAMILY PRACTICE, NESSET 1775 BALLA
Billing Area: FAM PRAC NESSET 110
Special Billing Date:

Diagnoses

Primary	#	Code	Description
Yes	1	(M79.673)	Heel pain
	2	(M76.70)	Peroneal tendinitis

Charges

Status	Units	Code	Mod	Description	Linked DX	Submitted by
Submitted	1	99214		Est Patient: Mod Complexity	1,2	Peindexter, Clemons

Printed by: Powell, Anita

1

Date 11/7/17 8:21PM

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

PCP Acute Care Note
12/15/2016 3:30PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

Reason For Visit

MARICEL MARCIAL is an established patient here today for a chief complaint of right foot pain.
Translator: interpreter services not used.
A chaperone is not applicable. She is unaccompanied.

Quality

Adult Wellness CI height documented, discussion of regular exercise, exercising regularly, printed information given for activities, discussion of nutritional quality of diet, patient education given about proper diet, not using alcohol, no tobacco use, does not have feelings of hopelessness and no Anhedonia.

History of Present Illness

Pt here for right foot pain for the past five days
-Pt was getting ready for a run and felt a pain over the lateral foot near the calcaneus
-Pain then resolved after running
-Pt then woke up the next day and pain was worse and pt had trouble bearing weight
-Pain was worse with walking
Now having trouble weight bearing and walking on her toes
-Denies any injury
-Denies N/T

Review of Systems

All other systems reviewed and negative.

Allergies

No Known Drug Allergies

Current Meds

1. Flonase Allergy Relief 50 MCG/ACT Nasal Suspension;
Therapy: 10Oct2016 to Recorded
2. Zyrtec Allergy 10 MG Oral Capsule;
Therapy: 10Oct2016 to Recorded

Active Problems

Anxiety (300.00) (F41.9)
Encounter for routine gynecological examination (V72.31) (Z01.419)
Encounter for screening for respiratory tuberculosis (V74.1) (Z11.1)
Fasting hyperglycemia (790.21) (R73.01)
Fibrocystic breast disease (610.1) (N60.19)
Neck Strain (847.0)
• post MVA
Nonspecific reaction to tuberculin skin test without active tuberculosis (795.51) (R76.11)

Page 1 of 3 printed 11/07/2017 8:21PM

PCP Acute Care Note
12/15/2016 3:30PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

Palpitations (785.1) (R00.2)
Routine History And Physical (V70.0)
Vertigo (780.4) (R42)
Visit for screening mammogram (V76.12) (Z12.31)

Past Medical History

History of breast lump (V13.89) (Z87.898)

Surgical History

Denied: History Of Prior Surgery

Family History

Mother

Family history of Duct, Solid Type, Carcinoma In Situ Of The Breast
• diagnosed at age 54

Paternal Aunt

Family history of Breast Cancer (V16.3)

Family History

Family history of Breast Cancer (V16.3)
Family history of Diabetes Mellitus (V18.0)

Social History

Denied: Alcohol
Denied: Considered Quitting Drinking Alcohol
Denied: Drinking Alcohol Regularly, Feeling Guilty About It
Denied: Drug Use
Exercising Regularly
Denied: Getting Angry When Talked To About Drinking
Denied: Having A Drink Or Two In The Morning To Get Going
Never smoker
Denied: Tobacco Use

Vitals

Vital Signs

Recorded: 15Dec2016 03:45PM

Height: 5 ft 4 25 in
Weight: 153 lb 6 oz
BMI Calculated: 26.12
BSA Calculated: 1.75
Systolic: 105, LUE, Sitting
Diastolic: 64, LUE, Sitting
Temperature: 97.6 F, Temporal
Heart Rate: 73
Respiration: 14

Physical Exam

Constitutional: alert, in no acute distress and current vital signs reviewed.
Head and Face: atraumatic, normocephalic.
Eyes: no discharge. extraocular movements were intact.
Pulmonary: no respiratory distress, normal respiratory rate and effort and no accessory muscle use.
Cardiovascular: edema was not present in the lower extremities.
Musculoskeletal: toe walking on the right side. TTP over the lateral foot between the calcaneus and 5th met
No pain with IV/EV/PP/DF

PCP Acute Care Note
12/15/2016 3:30PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

No TTP over ATFL, CFL, Achilles
SILT L3-S2
Skin, Hair, Nails: normal skin color and pigmentation and no rash.

Assessment

Heel pain (729.5) (M79.673)
• Assessed By: YOST, KYLE (Primary Care); Last Assessed: 15 Dec 2016
Peroneal tendonitis (726.79) (M76.70)

Plan

DME/Orthotics/Prosthetics Treatment and Evaluation For: Peroneal tendonitis
Questionable peroneal brevis avulsion off 5th met. Status: Active. Requested
for: 15Dec2016
(MU) Care Summary provided: : Yes

Plans:

Plan:

Xray reviewed by Dr. Skiba and I which showed a possible avulsion off the 5th met from a peroneal brevis injury. It is possible it is an accessory bone but with the irregularity of the base of the 5th met most likely an avulsion injury.

Non Pneumatic CAM Walker ordered
Pt to WBAT in CAM Boot
Pt may work but may take off if pain too severe in boot
Tylenol for pain

H/U in 2 weeks or sooner if needed.
Medical compliance with plan discussed and risks of non-compliance reviewed.
Patient education completed on disease process, etiology & prognosis.
Patient expresses understanding of the plan.
Proper usage and side effects of medications reviewed & discussed.
Refer to orders.
Return to clinic as clinically indicated as discussed with patient who verbalized understanding of & agreement with the plan.
XR FOOT RT MIN 3V: Status: Complete; Done: 15Dec2016
Perform: Other; Due: 14Jan2017; Last Updated By: Brunner, Kristyn; 12/15/2016 4:43:27 PM; Ordered:
For: Heel pain; Ordered By: YOST, KYLE;
Annotations
Right sides pain near calcaneus and 5th met. Possible fracture

Attending Note

I saw and evaluated the patient. I discussed the patient's case with the Resident. I agree with the Resident's findings and plan, as documented in today's note. PFS

Signatures

Electronically signed by : Delia Gallegos, L.P.N.; Dec 15 2016 3:47PM CST
Electronically signed by : SHELLY VERMA, DO; Dec 15 2016 5:23PM CST
Electronically signed by : KYLE YOST, DO; Dec 15 2016 5:25PM CST
Electronically signed by : PHILIP SKIBA, DO; Dec 16 2016 4:04PM CST

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date 10Oct2016 2:15PM
Provider: MEROLA, MELINDA (800901)
Dept: Int Med, 1775 Ballard-Nesset
Appt Loc: 1775 Ballard, Internal Med Nesset
For:
Appt No.: 31823131
Pt Ins: PPO BLUE CROSS
Special Billing:
CRF #:

Billing Provider: DECEMBER, MARI BETH
Compliance Code:
Performing Provider: MEROLA, MELINDA
Referring Provider:
Division: GENERAL INTERNAL MEDICINE
Location: NESSET INTERNAL MEDICINE
Billing Area: INT MED NESSET 140
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	(Z00.00)	Encounter for preventive health examination
	2	(R73.01)	Fasting hyperglycemia

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	99396		Est Prev Med: Age 40-64	1,2	Wright, Kelly

Printed by: Powell, Anita

1

Date: 11/7/17 8:21PM

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

PCP Primary Care Note
10/10/2016 2:15PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

Reason For Visit

MARICEL MARCIAL is an established patient here today for an annual physical. wants ob referral.
A chaperone is not applicable. She is unaccompanied.

Quality

Adult Wellness Cf height documented, discussion of regular exercise, exercising regularly, printed information given for activities, discussion of nutritional quality of diet, patient education given about proper diet, alcohol use, not having considered quitting drinking, not getting angry when talked to about drinking, not having a drink or two in the morning to get going, not drinking alcohol regularly, and feeling guilty about it, no tobacco use, did not provide intervention and counseling in regards to tobacco use, pap smear performed: 06/19/2012, does not have feelings of hopelessness, no Anhedonia and preventive medicine therapy for influenza.

History of Present Illness

Marcel came in today for annual physical as it has been a couple of years. She is feeling well and past issues with vertigo and palpitations have dissipated. She works as an ICU nurse at LGH.

Has not had labs in 2 years, had elevated fasting blood sugars.
Last pap with reflex in 2012, due next year.
Due for mamm.

UTD on TDap, will get record from employee health.
Will get flu shot at employee health.

Review of Systems

Const: Normal.
Allergy & Immunology: Normal.
Eyes: Normal.
ENT: Normal.
CV: Normal.
Resp: Normal.
Breast: Normal.
GI: Normal.
GU: Normal.
Endo: Normal.
Heme/Lymph: Normal.
Musc: Normal.
Neuro: Normal.
Psych: Normal.
Skin: Normal.

Allergies

Page 1 of 4 printed 11/07/2017 8:21PM

PCP Primary Care Note
10/10/2016 2:15PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

No Known Drug Allergies

Current Meds

1. Flonase Allergy Relief 50 MCG/ACT Nasal Suspension;
Therapy: 10Oct2016 to Recorded
2. Zyrtec Allergy 10 MG Oral Capsule;
Therapy: 10Oct2016 to Recorded

Active Problems

Anxiety (300.00) (F41.9)
Encounter for routine gynecological examination (V72.31) (Z01.419)
Encounter for screening for respiratory tuberculosis (V74.1) (Z11.1)
Fibrocystic breast disease (610.1) (N60.19)
Neck Strain (847.0)

- post MVA

Nonspecific reaction to tuberculin skin test without active tuberculosis (795.51) (R76.11)
Normal Routine History And Physical (V70.0)
Palpitations (785.1) (R00.2)
Vertigo (780.4) (R42)

Past Medical History

History of breast lump (V13.89) (Z87.898)

Surgical History

Denied: History Of Prior Surgery

Family History

Mother

Family history of Duct, Solid Type, Carcinoma In Situ Of The Breast

- diagnosed at age 54

Paternal Aunt

Family history of Breast Cancer (V16.3)

Family History

Family history of Breast Cancer (V16.3)
Family history of Diabetes Mellitus (V18.0)

Social History

Denied: Alcohol
Denied: Considered Quitting Drinking Alcohol
Denied: Drinking Alcohol Regularly, Feeling Guilty About It
Denied: Drug Use
Exercising Regularly
Denied: Getting Angry When Talked To About Drinking
Denied: Having A Drink Or Two In The Morning To Get Going
Never smoker
Denied: Tobacco Use

Vitals

Vital Signs [Data Includes: Current Encounter]

Recorded: 10Oct2016 02:33PM

Height: 5 ft 4.25 in
Weight: 154 lb
BMI Calculated: 26.23

PCP Primary Care Note
10/10/2016 2:15PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

BSA Calculated: 1.76
Systolic: 107, RUE, Sitting
Diastolic: 73, RUE, Sitting
Temperature: 97.5 F, Tympanic
Heart Rate: 75, R Radial

Physical Exam

Constitutional: alert, in no acute distress and current vital signs reviewed.

Head and Face: atraumatic, no deformities, normocephalic, normal facies, no tenderness of facial sinuses.

Eyes: no discharge, normal conjunctiva, no eyelid swelling, no ptosis and the sclerae were normal. pupils equal, round and reactive to light and accommodation and extraocular movements were intact.

ENT: normal appearing outer ear, normal appearing nose. examination of the tympanic membrane showed normal landmarks, normal appearing external canal. some white scarring on BL tympanic membranes, no current ear sx. nasal mucosa moist and pink, no nasal discharge, nasal septum midline, normal nasal turbinates. normal lips. oral mucosa pink and moist, no oral lesions, tonsils not enlarged, normal appearing pharynx, normal appearing tongue.

Neck: normal appearing neck and supple neck. thyroid not enlarged.

Lymphatic: no lymphadenopathy.

Pulmonary: no respiratory distress, normal respiratory rate and effort and no accessory muscle use. breath sounds clear to auscultation bilaterally.

Cardiovascular: normal rate, no murmurs were heard and regular rhythm. edema was not present in the lower extremities.

Abdomen: soft, nontender, nondistended, normal bowel sounds and no abdominal mass.

Musculoskeletal: normal gait, normal range of motion, muscle strength and tone were normal.

Neurologic: cranial nerves grossly intact, no sensory deficits noted, no coordination deficits, normal gait, muscle strength and tone were normal.

Psychiatric: oriented to person, oriented to place and oriented to time, alert and awake, interactive and mood/affect were appropriate.

Skin, Hair, Nails: normal skin color and pigmentation and no rash, no skin lesions.

Assessment

Encounter for preventive health examination (V70.0) (Z00.00)

Fasting hyperglycemia (790.21) (R73.01)

Visit for screening mammogram (V76.12) (Z12.31)

Plan

BASIC METABOLIC PNL; Status:Active; Requested for:10Oct2016;

CBC WITH AUTOMATED DIFFERENTIAL; Status:Active; Requested for:10Oct2016;

HEMOGLOBIN A1C GLYCOSYLATED; Status:Active; Requested for:10Oct2016;

LIPID PNL; Status:Active; Requested for:10Oct2016;

MA FFDM SCREEN BIL W TOMO W CAD; Status:Active; Requested for:10Oct2016;

VITAMIN D,25 HYDROXY; Status:Active; Requested for:10Oct2016;

Administer: Fluzone Quadrivalent 0.5 ML Intramuscular Suspension; INJECT 0.5 ML Intramuscular; To Be Done: 10Oct2016

OB-GYN Referral/Consult Treatment and Evaluation: Women's Wellness, due for pap with reflex in 2017 Status: Active Requested for: 10Oct2016

(MU) Care Summary provided. : Yes

Discussion/Summary

Ms Marcial is here for her annual complete physical exam.

1. Health Maintenance

- annual labs ordered, added A1c given FHx and h/o fasting hyperglycemia

- ordered mamm

- UTD on paps, due next year, would like referral to OBGYN, provided.

PCP Primary Care Note
10/10/2016 2:15PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

- will get flu shot at employee health and record of last TDap

RTC in 2 years.
- M Burnoski, DO

Attending Note

I discussed the patient's case with the Resident. I agree with the Resident's findings and plan, as documented in today's note.

Signatures

Electronically signed by : Shada Posey, RMA; Oct 10 2016 2:34PM CST

Electronically signed by : MELINDA BURNOSKI, MD; Oct 10 2016 3:30PM CST

Electronically signed by : MARIBETH DECEMBER, M.D.; Oct 10 2016 3:45PM CST (Author)

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date: 11Apr2014 1:30PM
Provider: ZONG, KANGNI (5190)
Dept: Int Med, 1775 Ballard-Nesset
Appt Loc: 1775 Ballard, Internal Med Nesset
For:
Appt No.: 22425772
Pt Ins: PPO BLUE CROSS
Special Billing:
CRF#:

Billing Provider: HOLMES, THOMAS
Compliance Code:
Performing Provider: ZONG, KANGNI
Referring Provider:
Division: GENERAL INTERNAL MEDICINE
Location: NESSET INTERNAL MEDICINE
Billing Area: INT MED NESSET 140
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	(R42)	Vertigo

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	99213		Est Patient: Low Complexity	1	Weichman, Debra

Printed by: Powell, Anita

1

Date: 11/7/17 8:21PM

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Letter

04/11/2014 1:30PM

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

April 11, 2014

To Whom It May Concern:

I have evaluated Ms. Maricel Marcial at Nessel Clinic today. Based on my exam, she is physically stable to return to normal educational and clinical duties.

Please call should you have any questions.

Sincerely,

Kangni Zong, MD MPH

Electronically signed by: KANGNI ZONG MD Apr 11 2014 2:08PM CST

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

PCP Acute Care Note
04/11/2014 1:30PM

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

Chief Complaint

• here for follow up visit from last week- lightheadedness states was gotten worse

Chaperone

Patient not accompanied by a family member.

HPI

Ms. Marcial is well known to me

She is here for l/u of dizziness

Also having nausea as well

She feels the dizziness can be elicited with just lateral gaze

Dr Stone who works with her at LGH recommended seeing Dr Dennis Moore for BPPV. Dr Moore was unable to elicit nystagmus with Dix-Hallpike and tested warm calories. He also ordered a video nystagography, which she had done this morning. He is also recommending an MRI to r/o Schwannoma.

She has no hearing symptoms. Her dizziness improves with rest, and symptoms do not interfere with her daily activities.

Active Problems

Anxiety (300.00)

Encounter for routine gynecological examination (V72.31)

Encounter for screening for respiratory tuberculosis (V74.1)

Fibrocystic breast disease (610.1)

Neck Strain (847.0),

* post MVA, 12 Aug 2009

Nonspecific reaction to tuberculin skin test without active tuberculosis (795.51)

Normal Routine History And Physical (V70.0)

Palpitations (785.1)

Vertigo (780.4).

PMH

History of breast lump (V13.89).

PSH

Denied History Of Prior Surgery.

Family Hx

Breast Cancer (V16.3); Maternal second cousin diagnosed in her 40's

Breast Cancer: Paternal Aunt (V16.3); diagnosed in her 60's

Diabetes Mellitus (V18.0)

Duct, Solid Type, Carcinoma In Situ Of The Breast. Mother, diagnosed at age 54.

Personal Hx

Denied Alcohol

Denied Considered Quitting Drinking Alcohol

Denied Drinking Alcohol Regularly, Feeling Guilty About It

Printed By: Anita Powell

1 of 3

11/7/17 8:21:52 PM

PCP Acute Care Note

Patient: MARICEL Q. MARCIAL
Encounter: Apr 11 2014 1:30PM

SSN: XXX-XX-7272
EMRN: 00341329

Denied Drug Use
Exercising Regularly
Denied Getting Angry When Talked To About Drinking
Denied Having A Drink Or Two In The Morning To Get Going
Never smoker
Denied Tobacco Use.

Allergies

Rec: 11Apr2014. List Reconciled and Reviewed.
No Known Drug Allergy.

Current Meds

Rec: 11Apr2014. List Reconciled and Reviewed.
Meclizine HCl - 25 MG Oral Tablet, TAKE 1 TABLET AT BEDTIME., Rx.

Vital Signs

Vital Signs Recorded by Gonzalez, Martha on April 11, 2014 01:38 PM
Height: 64 in, Weight: 148 lb, BMI: 25.40, BSA: 1.72
BP: 80/50 mm Hg R/UE Sitting
Temp: 97.3 F Tympanic
HR: 68 b/min R Radial, Regular

Physical Exam

Vital Signs:

° Current vital signs reviewed.

General Appearance:

° Normal.

Head:

° Normal.

Eyes:

General/bilateral:
° Eyes: normal.

Lungs:

° Clear to auscultation.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.
Heart Sounds: ° Normal.
Murmurs: ° No murmurs were heard.
Arterial Pulses: ° Equal bilaterally and normal.
Edema: ° No pitting edema.

Neurological:

• System: +dix-hallpike to left.

Assessment

Vertigo (780.4).

Plan

41yo female here for f/u of vertigo
- continue to suspect BPPV
- reviewed epley maneuver with patient, encourage to do at home
- encourage rest and hydration
- ok to return to clinical activities for CNA (nurse anesthetist) school, letter written
- if symptoms persist for next few days, consider prednisone for possible neuritis as she had URI 4 weeks ago
- pt awaiting result of nystagmography

Printed By: Anita Powell

2 of 3

11/7/17 8:21:53 PM

PCP Acute Care Note

Patient: MARICEL Q. MARCIAL
Encounter: Apr 11 2014 1:30PM

SSN: XXX-XX-7272
EMRN: 00341329

RTC pin

d/w Dr Holmes

K Zong

Discussed at time of visit. Pt returns for f/u vertigo. Has gotten little relief with meclizine. Agree with trial of modified epley at home and whatever steps can be taken to minimize stress at school. TH.

Signature

Electronically signed by : Martha Gonzalez CMA; 04/11/2014 1:40 PM CST.

Electronically signed by : KANGNI ZONG MD; 04/11/2014 4:11 PM CST.

Electronically signed by : THOMAS HOLMES M.D., 04/11/2014 4:23 PM CST.

Printed By: Anita Powell

3 of 3

11/7/17 8:21:54 PM

Advocate Medical Group

AMG-Sykes

2545 S. Martin Luther King Drive

Chicago, IL 60616

(312) 842-7117

Result Note

04/03/2014 2:13PM

Patient: MARICEL Q. MARCIAL**MRN:** 00341329**DOB:** 01/21/1973**Discussion/Summary**

All lab results look normal.

Verified ResultsCBC WITH AUTOMATED
DIFFERENTIAL

02Apr2014 04:45PM

TRAN, KIMBERLY

Test Name	Result	Flag	Reference
WBC	9.6 K/mL		4.2-11.0
RBC	4.36 mil/mL		4.00-5.20
HEMOGLOBIN	13.5 g/dl		12.0-15.5
HEMATOCRIT	41.4 %		36.0-46.5
MCV	95.0 fL		78.0-100.0
MCH	31.0 pg		26.0-34.0
MCHC	32.6 g/dl		32.0-36.5
RDWCV	12.8 %		11.0-15.0
PLATELET	277 K/mL		140-450
NEU%	66 %		
LYM%	24 %		
MON%	8 %		
EOS%	2 %		
BASO%	0 %		
NEU ABS	6.3 K/mL		1.8-7.7
LYM ABS	2.3 K/mL		1.0-4.8
MON ABS	0.8 K/mL		0.3-0.9
EOS ABS	0.2 K/mL		0.1-0.5
BASO ABS	0.0 K/mL		0.0-0.3
DIFF TYPE			
AUTOMATED DIFFERENTIAL			

BASIC METABOLIC PNL

02Apr2014 04:45PM

TRAN, KIMBERLY

Result Note
04/03/2014 2:13PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

Test Name	Result	Flag	Reference
SODIUM	139 mmol/L		135-145
POTASSIUM	4.0 mmol/L		3.4-5.1
CHLORIDE	104 mmol/L		98-107
CARBON DIOXIDE	26 mmol/L		21-32
ANION GAP	13 mmol/L		10-20
GLUCOSE	116 mg/dl	H	65-99
BUN	17 mg/dl		10-20
CREATININE	0.80 mg/dl		0.50-1.10
GFR EST.AFRICAN AMER	>60		>59
Units = mL/min/1.73m2			
GFR EST.NONAFRI AMER	>60		>59
Units = mL/min/1.73m2			
BUN/CREATININE RATIO	21		7-25
CALCIUM	9.4 mg/dl		8.4-10.2
FASTING STATUS	8 hrs		

TSH 02Apr2014 04:45PM TRAN, KIMBERLY

Test Name	Result	Flag	Reference
TSH	1.610 mcUnits/mL		0.350-5.000

Signatures

Electronically signed by : KIMBERLY TRAN, DO, Apr 3 2014 2:13PM CST (Author)

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Cardiology TTE
04/03/2014 11:20AM

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

Adult Echo

Patient: **MARCIAL, MARICEL**
DOB: **01/21/1973**
H: **64 in**, W: **145 lbs**, BSA: **1.71 m²**
Study Date: **4/3/2014 11:16:42 AM**
Referring Physician: **Holmes, Thomas, MD**
Physical:
cc:

Account #: **00341**
Study Quality: **G**

Referring Cardiolo

Symptoms:

Indications: Palpitations

Procedure

A complete 2D, M-Mode, Spectral Doppler and Color Doppler echocardiogram was performed in the apical, parasternal and subcostal views.

Conclusions

1. The patient was in normal sinus rhythm.
2. The left ventricular cavity size appears normal. The left ventricular wall thickness appears normal. Left ventricular ejection fraction was normal, estimated in the range of 60 to 65%. Left ventricular wall motion analysis appears normal.
3. There is pericardial effusion of trivial size.
4. Overall normal study.

Findings

General: The patient was in normal sinus rhythm. BP 100/70

Left Ventricle: The left ventricular cavity size appears normal. The left ventricular wall thickness appears normal. The shape of the left ventricle appears normal. Diastolic

Printed By: Anita Powell

1 of 3

11/7/17 8:21:59 PM

Cardiology TTE

Patient: MARICEL Q. MARCIAL
 Encounter: Apr 3 2014 11:20AM

SSN: XXX-XX-7272
 EMRN: 00341329

filling appears normal for the patient's age. Left ventricular ejection fraction was normal, estimated in the range of 60 to 65%. Left ventricular wall motion analysis appears normal.

Right Ventricle: The right ventricular cavity size appears normal. The right ventricular wall thickness appears normal. The right ventricular systolic function appears normal.

Left Atrium: The left atrial size appears normal.

Right Atrium: The right atrial size appears normal.

Aortic Valve: The structure of the aortic valve is tricuspid. There is no evidence of aortic stenosis. There is no evidence of aortic regurgitation.

Mitral Valve: There is no evidence of mitral stenosis. There is no evidence of mitral regurgitation. The mitral valve appears normal in structure.

Pulmonic Valve: The pulmonic valve was not well visualized.

Tricuspid Valve: There is no evidence of tricuspid regurgitation. There is no evidence of tricuspid stenosis. The tricuspid valve appears normal in structure.

Pericardium: The pericardium appears normal. There is pericardial effusion of trivial size.

Aorta: The visualized portions of the aorta appear normal.

Pulmonic Artery: The pulmonary artery was not well visualized.

Venous: The pulmonary veins were not well visualized.

Measurements

MVA (P1/2t)	2.74 cm ²	SV (LVOT)	56.3 ml	ESV (A2C)	18.3 ml	LA/Ao	1.18
MV P1/2t	95.8 cm/s	LVOT VTI	19.7 cm	EDV (A4C)	67.7 ml	LA Dimen	3.57 cm
Vmax							
MV Peak A	67.8 cm/s	TR Vmax	188 cm/s	ESV (A4C)	17 ml	AV Vmax	113 cm/s
Vel							
MV E/A	1.33	AoR Diam	3.02 cm	Vis Est EF	65 %	AV Max PG	5 mmHg
MV Peak E Vel	90 cm/s	TR Max PG	14 mmHg	FS (Teich)	41.2 %	AV Vmean	78.9 cm/s
MV P1/2t	80.4 msec	LVOT Mean PG	2 mmHg	EDV (A2C)	73.2 ml	LVPWs	1.19 cm
AV VTI	24.3 cm	LVOT Diam	1.91 cm	SV (BP)	56.7 ml	LVIDd	4.84 cm
AV Mean PG	3 mmHg	MV Decel Time	0.13 msec	SV (A4C)	50.7 ml	IVSd	0.89 cm
AVA (Vmax)	2.39 cm ²	LVOT Vmax	94.8 cm/s	EF (Teich)	72 %	LVPWd	0.81 cm
AV Cusp Sep	1.91 cm	LVOT Max PG	4 mmHg	EF (BP)	76 %	IVSs	1.36 cm

Printed By: Anita Powell

2 of 3

11/7/17 8:22:00 PM

Cardiology TTE

Patient: MARICEL Q. MARCIAL
Encounter: Apr 3 2014 11:20AM

SSN: XXX-XX-7272
EMRN: 00341329

AVA (VTI) 2.32 cm² LVOT Vmean 63.7 cm/s EF (A4C) 74.9 % LVIDs 2.85 cm

Sonographer: **Negru, Felicia, R.C.S.**

Electronically signed by: NAYLA CHAPTINI M.D. Apr 3 2014 6:48PM CST Author

Printed By: Anita Powell

3 of 3

11/7/17 8:22:00 PM

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date 03Apr2014 11:20AM
Provider: ECHO/ABLNESSET (51477)
Dept: RESOURCES,CARD NESSET
Appt Loc: NES
For:
Appt No.: 22375342
Pt Ins: PPO BLUE CROSS
Special Billing:
CRF #:

Billing Provider:
Compliance Code:
Performing Provider: ECHO/ABI, NESSET
Referring Provider: HOLMES, THOMAS MD
Division:
Location:
Billing Area:
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	(R00.2)	Palpitations
	2	(R42)	Vertigo

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	93306		ECHO TTHRC R-T 2D - +M-MODE COMPL SPEC COLOR DOP	1,2	Caruso, Linda

Printed by: Powell, Anita

1

Date: 11/7/17 8:22PM

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # 16790639LU912BPNI
Ordering Provider: TRAN, KIMBERLY
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 04/02/2014 4:45:00PM
Resulted: 04/03/2014 12:35:00AM
Verified By: TRAN, KIMBERLY
Auto Verify: N

BASIC METABOLIC PNL

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
SODIUM	139	mmol/L	135-145
POTASSIUM	4.0	mmol/L	3.4-5.1
CHLORIDE	104	mmol/L	98-107
CARBON DIOXIDE	26	mmol/L	21-32
ANION GAP	13	mmol/L	10-20
GLUCOSE	116	mg/dl	II 65-99
BUN	17	mg/dl	10-20
CREATININE	0.80	mg/dl	0.50-1.10
GFR EST.AFRICAN AMER Units = mL/min/1.73m2	>60		>59
GFR EST.NONAFRI AMER Units = mL/min/1.73m2	>60		>59
BUN/CREATININE RATIO	21		7-25
CALCIUM	9.4	mg/dl	8.4-10.2
FASTING STATUS	8	hrs	

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession #: 16790639LU912CBCA
Ordering Provider: TRAN, KIMBERLY
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 04/02/2014 4:45:00PM
Resulted: 04/03/2014 12:08:00AM
Verified By: TRAN, KIMBERLY
Auto Verify: N

CBC WITH AUTOMATED DIFFERENTIAL

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
WHITE BLOOD COUNT	9.6	K/mcL	4.2-11.0
RED CELL COUNT	4.36	mil/mcL	4.00-5.20
HEMOGLOBIN	13.5	g/dl	12.0-15.5
HEMATOCRIT	41.4	%	36.0-46.5
MEAN CORPUSCULAR VOLUME	95.0	fL	78.0-100.0
MEAN CORPUSCULAR HEMOGLOBIN	31.0	pg	26.0-34.0
MEAN CORPUSCULAR HGB CONC	32.6	g/dl	32.0-36.5
RDW-CV	12.8	%	11.0-15.0
PLATELET COUNT	277	K/mcL	140-450
NEU%	66	%	
LYM%	24	%	
MON%	8	%	
EOS%	2	%	
BASO%	0	%	
NEU ABS	6.3	K/mcL	1.8-7.7
LYM ABS	2.3	K/mcL	1.0-4.8
MON ABS	0.8	K/mcL	0.3-0.9
EOS ABS	0.2	K/mcL	0.1-0.5
BASO ABS	0.0	K/mcL	0.0-0.3
DIFF TYPE	AUTOMATED DIFFERENTIAL		

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession #: 16790639LU912TSH
Ordering Provider: TRAN, KIMBERLY
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 04/02/2014 4:45:00PM
Resulted: 04/03/2014 12:35:00AM
Verified By: TRAN, KIMBERLY
Auto Verify: N

TSH

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
TSH	1.610	mcUnits/mL	0.350-5.000

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date 02Apr2014 3:15PM
Provider: TRAN, KIMBERLY (956625)
Dept: Int Med, 1775 Ballard-Nesset
Appt Loc: 1775 Ballard, Internal Med Nesset
For:
Appt No.: 22367738
Pt Ins: PPO BLUE CROSS
Special Billing:
CRF #:

Billing Provider: HOLMES, THOMAS
Compliance Code:
Performing Provider: TRAN, KIMBERLY
Referring Provider:
Division: GENERAL INTERNAL MEDICINE
Location: NESSET INTERNAL MEDICINE
Billing Area: INT MED NESSET 140
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	(R42)	Vertigo
	2	(F41.9)	Anxiety

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	99213		Est Patient Low Complexity	1,2	Weichman, Debra

Printed by: Powell, Anita

1

Date: 11/7/17 8:22PM

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Letter
04/02/2014 3:15PM

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

Marcial, Maricel was seen in my office today 4/2/14 for workup for palpitations and lightheaded. Please excuse patient from school for the next week until she is medically clear from us to return back to school.

Electronically signed by: KIMBERLY TRAN DO Apr 2 2014 4:28PM CST Author

Printed By: Anita Powell

1 of 1

11/7/17 8:22:16 PM

**Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117**

**PCP Acute Care Note
04/02/2014 3:15PM**

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

Chief Complaint

- "c/o palpitations and lightheadiness" not taking citalopran

Quality

No feelings of hopelessness. No anhedonia. No Pap smear was performed 2 years ago. Discussion of nutritional quality of diet. No tobacco use and not using alcohol. Education: exercising regularly. Printed information given for activities. Able to walk. Height.
Patient/caregiver queried about falls; Influenza immunization at lgh; Discussion of regular exercise; Printed information given for patient education about a proper diet

HPI

41 year old female with past medical history of PVCs. Patient is a student for CRNA at Rush and works as an ICU nurse at LGH. Patient states she has been stressed out a lot with school. Patient states that there has been a lot of bully in her class.

Complains of intermittent palpitations that has been ongoing since January 2014. Patient complains of symptoms of lightheadedness that occurs only when she is standing for a prolonged time period. During these episodes, patient experiences blurry vision. No fainting or LOC. Patient does complaining of bilateral ear fullness and tinnitus mainly in the right ear that has been ongoing for the past month. No sensation of room spinning. Baseline SBP 90-100s. Patient states that she gets nauseous with turning. Patient was seen at urgent care yesterday. 12 Lead EKG performed 4/1/14 revealed NSR.

ROS

Systemic: Systemic symptoms general overall feeling. Feeling fine. No fever and no chills.

Head: No head symptoms.

Neck: No neck symptoms.

Eyes: No eye symptoms.

Otolaryngeal: Ear symptoms ear fullness. No nasal symptoms and no throat symptoms.

Cardiovascular: Cardiovascular symptoms history of PVCs.

Pulmonary: No pulmonary symptoms, no dyspnea, no cough, and no wheezing.

Gastrointestinal: Gastrointestinal symptoms with head movements. Normal appetite. Nausea No vomiting.

Endocrine: No endocrine symptoms.

Hematologic: No hematologic symptoms.

Musculoskeletal: No musculoskeletal symptoms.

Neurological: Dizziness. No vertigo. Lightheadedness. No fainting, no decrease in consciousness, no decrease in concentrating ability, no confusion, no disorientation, no delirium, no convulsions, no speech difficulties, and no sensory disturbances.

Psychological: Psychological symptoms anxiety.

Skin: No skin symptoms.

Allergic and Immunologic: No allergic/immunologic symptoms.

Printed By: Anita Powell

1 of 4

11/7/17 8:22:18 PM

PCP Acute Care Note

Patient: MARICEL Q. MARCIAL
Encounter: Apr 2 2014 3:15PM

SSN: XXX-XX-7272
EMRN: 00341329

Active Problems

Breast Fibrocystic Disease (610.1)
Neck Strain (847.0);
* post MVA, 12 Aug 2009
Normal Routine History And Physical (V70.0)
Palpitations (785.1)
Tuberculin PPD Induration Positive Interpretation (795.5)
Visit For: Screening Exam Pulmonary Tuberculosis (V74.1)
Visit For: Single System Exam Gynecological With Pap Smear (V72.31).

PMH

Breast Palpation Mass (611.72).

PSH

Denied History Of Prior Surgery.

Family Hx

Breast Cancer (V16.3); Maternal second cousin diagnosed in her 40's
Breast Cancer; Paternal Aunt (V16.3); diagnosed in her 60's
Diabetes Mellitus (V18.0)
Duct, Solid Type, Carcinoma In Situ Of The Breast: Mother; diagnosed at age 54.

Personal Hx

Denied Alcohol
Denied Considered Quitting Drinking Alcohol
Denied Drinking Alcohol Regularly, Feeling Guilty About It
Denied Drug Use
Exercising Regularly
Denied Getting Angry When Talked To About Drinking
Denied Having A Drink Or Two In The Morning To Get Going
Never A Smoker
Denied Tobacco Use.

Allergies

No Known Drug Allergy.

Current Meds

No Reported Medications;; RPT.

Vital Signs

Recorded by Kling, Geraldine on 02 Apr 2014 03:30 PM
BP: 100/70, LUE, Sitting,
HR: 72 b/min, L Radial, Regular,
Temp. 97 F, Tympanic,
Height: 64 in, Weight: 145.1875 lb, BMI: 24.9 kg/m2,
BMI Calculated: 24.92 ,
BSA Calculated: 1.71.

Physical Exam

Vital Signs:

° Current vital signs reviewed.

General Appearance:

• General appearance: ° Well-appearing.

Head:

° Normal.

Neck:

Thyroid: ° Showed no abnormalities.

Eyes:

Printed By: Anita Powell

2 of 4

11/7/17 8:22:18 PM

PCP Acute Care Note

Patient: MARICEL Q. MARCIAL
Encounter: Apr 2 2014 3:15PM

SSN: XXX-XX-7272
EMRN: 00341329

General/bilateral:
° Eyes: normal.
Ears, Nose, Throat:
° ENT: normal.
Ears:
General/bilateral:
° Ears: normal.
Nose:
General/bilateral:
° Nose: normal.
Oral Cavity:
° Normal.
Pharynx:
° Normal.
Lymph Nodes:
° Normal.
Lungs:
° Normal breath sounds/voice sounds. ° No wheezing was heard. ° No rhonchi were heard.
Cardiovascular:
Heart Rate And Rhythm: ° Normal. ° Heart rate was normal. ° Heart rhythm regular.
Heart Sounds: ° Normal.
Murmurs: ° No murmurs were heard.
Arterial Pulses: ° Equal bilaterally and normal.
Edema: ° No pitting edema.
Abdomen:
° Normal.
Liver: ° Normal to palpation.
Musculoskeletal System:
General/bilateral: ° Musculoskeletal system: normal.
Neurological:
• System: positive dix hallpike maneuver with rotation to the right.
Speech: ° Normal.
Lateralizing Cortical Functions: ° Normal.
Cranial Nerves: ° Normal.
Sensation: ° No sensory exam abnormalities were noted.
Coordination / Cerebellum: ° No coordination/cerebellum abnormalities were noted.
Skin:
° Normal.

Assessment

Vertigo (780.4).
Anxiety (300.00).

Orders

CBC WITH AUTOMATED DIFFERENTIAL, Requested for: 02 Apr 2014.

BASIC METABOLIC PNL; Requested for: 02 Apr 2014.

TSH; Requested for: 02 Apr 2014.

CD ECHO 2D COMPLETE W DOP AND COLOR-ADLT, Requested for: 02 Apr 2014.

BuPROPION HCl ER (SR) 150 MG Oral Tablet Extended Release 12 Hour; TAKE 1 TABLET DAILY FOR 1 WEEK, THEN TAKE 1 TABLET TWICE DAILY, Qty60, R0; Rx.

Plan

41 year old female presents with lightheadedness

Printed By: Anita Powell

3 of 4

11/7/17 8:22:19 PM

PCP Acute Care Note

Patient: MARICEL Q. MARCIAL
Encounter: Apr 2 2014 3:15PM

SSN: XXX-XX-7272
EMRN: 00341329

Vertigo:

- most likely BPPV given positive dix hallpike maneuver
- orthostatics negative
- EKG 4/1/14 from urgent care reveals NSR
- will order CBC, BMP, TSH
- will order 2D echo
- note given for school

Anxiety:

- will try bupropion 150 mg daily x1 week, then increase to BID

F/U in 1 week

Seen and discussed at time of visit. Pt with c/o dizziness and palpitations. She is under a lot of stress at school, feels she is being misused. She is tearful and depressed. Has normal exam, some nystagmus with dix hallpike. Agree with plan, trial of bupropion and f/u as noted. TH.

Past Meds

~~Citalopram Hydrobromide 20 MG Oral Tablet;; Qty30; R0; RPT.~~

No Reported Medications;; Qty0; R0; RPT.

Signature

Electronically signed by : Geraldine Kling CMA; 04/02/2014 3:38 PM CST.

Electronically signed by : KIMBERLY TRAN DO; 04/02/2014 4:42 PM CST; Author.

Electronically signed by : THOMAS HOLMES M.D.; 04/02/2014 4:50 PM CST.

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date: 10Aug2012 9:00AM
Provider: COUNSELOR, GENETICS (29001)
Dept: Genetics, 1875 Dempster
Appt Loc: 1875 Dempster, genetics Parkside
For:
Appt No.: 17361936
Pt Ins: HMO HUMANA/ADVOCATE
Special Billing:
CRF #: 100004851

Billing Provider: MARCUS, SETH
Compliance Code:
Performing Provider: MARCUS, SETH
Referring Provider: DOLAN, JAMES 04852 HT1
Division: GENETICS
Location: PARKSIDE GENETICS
Billing Area: GENETICS PARKSIDE 166
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	Q	Family history breast cancer

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	2	96040		GENETIC COUNSELING, EA 30 MIN		Schulz, Marjorie

LMRP: J6 Medicare Administrative Contractor (MAC) National Government Services (NGS) (IL)

Printed by: Powell, Anita

1

Date: 11/7/17 8:22PM

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Genetics Counseling Report
08/10/2012 9:00AM

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

Chief Complaint

• Family History of Cancer

Referred By

Consultation requested by: Dr. Dolan.

Counseling/Coordination of Care

Ms. Marcial came to Genetics to investigate a possible hereditary cause of the family history of breast cancer.

History:

Ms. Marcial is a 39 yo woman with no personal history of cancer. For more than 10 years she has had palpable thickening of the right breast. She has had mammograms. Ms. Marcial reports that her mother, now 64, had ductal carcinoma in situ at age 55, a maternal aunt who was a cigarette smoker died of lung cancer at ~50, a maternal first cousin once-removed died in the Philippines in the 1980's in her 40's of breast cancer. On the paternal side of the family, a paternal aunt who was a cigarette smoker died of lung cancer at ~58, another paternal aunt, who is now 65, was diagnosed with invasive ductal carcinoma at 65, and the paternal grandfather, who died at 84, had prostate cancer in his 70's.

I discussed in detail the implications of the history of cancer. Most cancer is not due to a hereditary gene mutation. Hereditary cancer is suspected under certain conditions, such as when breast cancer occurs prior to the age of 50 (or premenopausal), when there are multiple affected family members, when breast cancer occurs in combination with other cancers, especially ovarian cancer, when breast cancer occurs on both the right and left sides (bilateral), and when cancer appears to be passing from generation to generation.

Neither the maternal nor paternal family histories are highly suggestive of a hereditary origin. The one relative with early onset breast cancer is a fourth degree relative of Ms. Marcial, that is, not very closely related. Ms. Marcial's mother's family is unrelated to her father's family, neither breast cancer nor prostate cancer is rare nor is lung cancer in cigarette smokers, and the other individuals with breast cancer/DCIS did not have it at an early age. While a hereditary origin to some or all of the cancer in the family is possible, there is not a high statistical probability of a hereditary mutation cause. While genetic testing is not often performed with such a history, if the family wishes to pursue testing, they may wish to first have testing performed on Ms. Marcial's mother: when genetic testing is performed in a family it is usually most informative to begin testing an affected family member first. The pro and cons of cancer predisposing gene mutation testing were reviewed with Ms. Marcial. Mutations in the genes BRCA1 and BRCA2 account for most cases (but not all) of hereditary breast cancer. If a mutation were found it would significantly alter risk assessment and medical management - but finding a mutation in this family at this time is not highly likely.

Genetics Counseling Report

Patient: MARICEL Q. MARCIAL
Encounter: Aug 10 2012 9:00AM

SSN: XXX-XX-7272
EMRN: 00341329

Ms. Marcial and family members should utilize screening methods for cancer. It may also be helpful to reduce the risk of certain cancers by diet, exercise, and possible food/supplement intake.

Ms. Marcial decided not to proceed with genetic testing at this time.

If she has questions or wishes to have genetic testing she should call. In light of the fact that there continues to be many advances in cancer genetics, Ms. Marcial should maintain contact with a genetic professional to keep informed of any new developments.

Signature

Electronically signed by . Seth Marcus MS,LCGC; 08/10/2012 1:56 PM CST.

Advocate Medical Group

AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Result Note

06/26/2012 4:30PM

Patient: MARICEL Q. MARCIAL
MRN: 00341329
DOB: 01/21/1973

Discussion/Summary

Maricel- Your pap smear from 6/19/12 was Normal

Signatures

Dr. James Dolan
Electronically signed by : Nicole Marcheschi, R.N.; Jun 26 2012 4:31PM (Co-author)

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date: 19Jun2012 2:30PM
Provider: DOLAN, JAMES (3606)
Dept: Gyn/onc, 1700 Luther Lane
Appt Loc: 1700 Luther Lane, Cancer Care Center
For:
Appt No.: 16783980
Pt Ins: HMO HUMANA/ADVOCATE
Special Billing:
CRE #:

Billing Provider: DOLAN, JAMES
Compliance Code:
Performing Provider: DOLAN, JAMES
Referring Provider:
Division: GYNE/ONCOLOGY
Location: WEST PAVILION
Billing Area: GYNE ONCOLOGY W PAVILION 162
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	0	ROUTINE GYNE EXAM
	2	0	Fibrocystic breasts

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	99214		Est Patient: Mod Complexity		Branick, Mary

Printed by: Powell, Anita

1

Date: 11/7/17 8:22PM

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Gyne Onc Consult - New Patient Visit
06/19/2012 2:30PM

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

Chaperone
Jun 19, 2012

Chaperone : Nicole.

Physicians

Primary Care Physician: Dr. Mark Conley
Requested by:

Chief Complaint

• MARICEL MARCIAL, a 39 year existing Breast Center patient is here for an Annual Breast Exam. Patient has a history of a palpable thickening in right breast for the past 10+ years. Patient was due for a mammogram prior to this apt - scheduled for 4:20pm today

Patient would like a pap smear

Quality

No tobacco use and not a former smoker.

HPI

She reported: Breast symptoms. Thickened area of skin in right breast more prominent around menses, unchanged for many years. Denies nipple discharge.
No pulmonary symptoms. Normal appetite, no nausea, no vomiting, and no change in stool. No urinary symptoms and no vaginal discharge or abnormal vaginal bleeding. Patient having a little residual spotting from menses 6/15/12.

Last Screening

Last PAP: 2004 Normal with Dr. Pesch. No h/o abnormal paps.

Last Mammogram:

Patient Name MARCIAL, MARICEL
MRN 692103 Date of Birth 01/21/1973
Ordered By CONLEY, MARK
Procedure Date 04/04/2011
Orig Approved By FRIEDEWALD, SARAH
* Final Report *

#32448574 - MA FFDM DIAGNOSTIC W CAD BIL

BILATERAL DIGITAL DIAGNOSTIC MAMMOGRAM WITH CAD: 4/4/2011

CLINICAL HISTORY: The patient is a 38 year old woman who presents with a palpable abnormality in her right breast.

FINDINGS:

Printed By: Anita Powell

1 of 6

11/7/17 8:22:32 PM

Gyne Onc Consult - New Patient Visit

Patient: MARICEL Q. MARCIAL
Encounter: Jun 19 2012 2:30PM

SSN: XXX-XX-7272
EMRN: 00341329

The tissue of both breasts is extremely dense, which lowers the sensitivity of mammography.
No significant masses, calcifications, or other findings are seen in either breast.
Current study was also evaluated with a Computer Aided Detection (CAD) system.

IMPRESSION: ADDITIONAL IMAGING EVALUATION RECOMMENDED
BIRADS Category 0, additional imaging is recommended. Negative mammogram.
Recommendation: Ultrasound of the right breast is recommended.

#32448575 - MA US BREAST RT
ULTRASOUND OF THE RIGHT BREAST : 4/4/2011
FINDINGS:

Real-time ultrasound was performed on the area of interest in the right breast.

No abnormality is identified in the region of the patient's palpable abnormality in the right breast at 10:00, 3 cm from the nipple.

IMPRESSION: NEGATIVE
BIRADS Category 1, negative. There is no mammographic or sonographic evidence of malignancy.

Recommendation: Management of the patient's palpable abnormality should be based on clinical grounds. A 1 year screening mammogram is recommended.

Findings and recommendations were discussed with the patient at the time of the examination both verbally and in writing.

Sarah Friedewald M.D.

**** FINAL ****

Signature Line
Electronically Signed
FRIEDEWALD, SARAH

Patient Name MARCIAL, MARICEL
MRN 692103 Date of Birth 01/21/1973
Test Description: MA FFDM DIAGNOSTIC W CAD BIL
Ordered By DOLAN, JAMES
Procedure Date 11/12/2009
Orig Approved By KEZDI ROGUS, PAULA
* Final Report *
#30180708 - MA FFDM DIAGNOSTIC W CAD BIL
BILATERAL DIGITAL DIAGNOSTIC MAMMOGRAM WITH CAD 11/12/2009

FINDINGS:
The tissue of both breasts is extremely dense, which lowers the sensitivity of mammography.
The grouped and scattered punctate calcifications in the superior and medial right breast are unchanged.
No significant masses, calcifications, or other findings are seen in either breast.
Current study was also evaluated with a Computer Aided Detection (CAD) system.

Printed By: Anita Powell

2 of 6

11/7/17 8:22:33 PM

Gyne Onc Consult - New Patient Visit

Patient: MARICEL Q. MARCIAL
Encounter: Jun 19 2012 2:30PM

SSN: XXX-XX-7272
EMRN: 00341329

IMPRESSION: ADDITIONAL IMAGING EVALUATION RECOMMENDED
Ultrasound of the palpable area in the right breast is recommended.

Ultrasound of the 10-12 o'clock right breast and 1-5 o'clock right breast in the region of the dense tissue and calcifications is recommended.

The patient could not stay for the ultrasound exam and will reschedule.

The findings and recommendations were discussed with the patient at the time of the examination both verbally and in writing.

MAMMOGRAPHY BI-RADS: 0 - ADDITIONAL IMAGING EVALUATION RECOMMENDED

Paula Kozdi-Rogus MD
**** FINAL ****

Patient Name MARCIAL, MARICEL
MRN 692103 Date of Birth 01/21/1973
Test Description: MR BREAST BIL WO/W CON
Ordered By DOLAN, JAMES
Procedure Date 01/20/2009
Orig Approved By FRIEDEWALD, SARAH
* Final Report *

FINDINGS

The breasts demonstrate moderate background enhancement which limits the sensitivity of breast MRI.

There is bilateral symmetric nodular enhancement of both breasts which demonstrates rapid contrast uptake and persistent delayed enhancement. No suspicious enhancing nodules with washout of contrast are identified with particular attention to the region of the patient's palpable abnormality in the right breast.

Evaluation of the axillary regions demonstrate normal appearing lymph nodes. Evaluation of the internal mammary regions is unremarkable.

IMPRESSION: PROBABLY BENIGN

BI-RADS Category 3, probably benign findings. Bilateral symmetric nodular enhancement of both breasts with no suspicious enhancing lesions.

Recommendation: A follow-up mammogram in 6 months is recommended to demonstrate stability of the microcalcifications in the upper outer quadrant and the lower inner quadrant of the right breast as previously recommended. A 1 year bilateral breast MRI is also recommended given the patient's strong family history to ensure stability of the nodular breast enhancement.

Sarah Friedewald M.D.

**** FINAL ****

Signature Line
Electronically Signed
FRIEDEWALD, SARAH

Printed By: Anita Powell

3 of 6

11/7/17 8:22:33 PM

Gyne Onc Consult - New Patient Visit

Patient: MARICEL Q. MARCIAL
Encounter: Jun 19 2012 2:30PM

SSN: XXX-XX-7272
EMRN: 00341329

Last Colorectal Screening:
Last DEXA Scan:
Last Chest X-Ray: 12/14/11 Impression: No acute cardiopulmonary disease radiographically.

Last Labs:

CT Scan:

Active Problems

Breast Palpation Mass (611.72)

Neck Strain (847.0);

* post MVA, 12 Aug 2009

Normal Routine History And Physical (V70.0)

Palpitations (785.1)

Tuberculin PPD Induration Positive Interpretation (795.5)

Visit For Screening Exam Pulmonary Tuberculosis (V74.1)

PGH

G: 0 P: 0

LMP: 6/15/12, regular

METHOD OF BC: None

Menarche age 13.

PMH

Reviewed.

PSH

Denied History Of Prior Surgery.

Current Meds

No Reported Medications;., RPT

Allergies

No Known Drug Allergy.

Family Hx

Family history of Breast Cancer; Maternal second cousin diagnosed in her 40's

Paternal aunt's history of Breast Cancer; diagnosed in her 60's

Family history of Diabetes Mellitus

Maternal history of Duct, Solid Type, Carcinoma In Situ Of The Breast; diagnosed at age 54.

Personal Hx

Denied Alcohol

Denied Considered Quitting Drinking Alcohol

Denied Drinking Alcohol Regularly, Feeling Guilty About It

Denied Drug Use

Exercising Regularly

Denied Getting Angry When Talked To About Drinking

Denied Having A Drink Or Two In The Morning To Get Going

Never A Smoker

Denied Tobacco Use.

ROS

Eyes: No eye symptoms.

Otolaryngeal: No ear symptoms, no nasal symptoms, and no throat symptoms.

Cardiovascular: No cardiovascular symptoms.

Gastrointestinal: No gastrointestinal symptoms.

Genitourinary: No genitourinary symptoms.

Endocrine: No endocrine symptoms.

Printed By: Anita Powell

4 of 6

11/7/17 8:22:34 PM

Gyne Onc Consult - New Patient Visit

Patient: MARICEL Q. MARCIAL
Encounter: Jun 19 2012 2:30PM

SSN: XXX-XX-7272
EMRN: 00341329

Hematologic: No hematologic symptoms.
Neurological: No neurological symptoms.
Psychological: No psychological symptoms.
Skin: No skin symptoms.

Vital Signs

Recorded by Marcheschi, Nicole on 19 Jun 2012 02:49 PM
BP 118/64, LUE,
Height: 65.000000 in, Weight: 139.500000 lb, BMI: 23.2 kg/m²,
BSA Calculated: 1.70,
BMI Calculated 23.24.

Physical Exam

General Appearance:

° Normal.

Head:

° Normal.

Neck:

Thyroid: ° Showed no abnormalities.

Ears, Nose, Throat:

° ENT: normal.

Lymph Nodes:

° Normal. ° Axillary lymph nodes were not enlarged. ° Axillary lymph nodes were not enlarged bilaterally.

Breasts:

General/bilateral.

° Breasts: normal. ° Appearance of the breast was normal. ° Palpation of the breast revealed no abnormalities.

Right Breast:

° Normal.

Left Breast:

° Normal.

Lungs:

° Normal.

Cardiovascular:

° System: normal.

Abdomen:

° Normal.

Musculoskeletal System:

General/bilateral ° Musculoskeletal system: normal.

Neurological:

° System: normal.

Gyne Exam

The inguinal lymph nodes were not enlarged. Genitalia: normal and the vagina was normal. Cervix normal and showed no lesion. The uterus was normal and the uterine adnexae were normal. Rectal Exam: normal. A stool sample was taken for occult blood analysis. A fecal occult blood test was negative.

Assessment

- Visit for: gynecological exam with pap smear (V72.31)
- History of a breast mass was found (611.72)
- Breast fibrocystic disease (610.1)

Plan

Pap Smear done

Mammogram Bilateral will perform today

Printed By: Anita Powell

5 of 6

11/7/17 8:22:34 PM

Gyne Onc Consult - New Patient Visit

Patient: MARICEL Q. MARCIAL
Encounter: Jun 19 2012 2:30PM

SSN: XXX-XX-7272
EMRN: 00341329

Pt to see Genetics re risk of BRCA mutation and need for poss testing

Return to office: here pm or 12 months for breast check

Follow up gen Gyne, Contact info given for AMG Gen Gyne

Amended: JAMES DOLAN M.D.; 06/19/2012 3:15 PM CST

Signature

Electronically signed by: JAMES DOLAN M.D.; 06/19/2012 3:13 PM CST; Author.

Electronically signed by: JAMES DOLAN M.D.; 06/19/2012 3:14 PM CST; Author.

Electronically signed by: JAMES DOLAN M.D.; 06/19/2012 3:42 PM CST; Author.

Printed By: Anita Powell

6 of 6

11/7/17 8:22:35 PM

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # RG12-55154
Ordering Provider: DOLAN, JAMES
Performing Location: ACL

Collected: 06/19/2012 12:00:00AM
Resulted: 06/26/2012 3:02:00PM
Verified By: DOLAN, JAMES
Auto Verify: N

PAP SMEAR WITH HPV REFLEX (THIN PREP ONLY)

Stage: Final

Result 06/26/2012 4:30:00PM Marcheschi, Nicole
Annotations: letter sent

Test**Result****Units****Flag Reference Range**

GYN PAP WITH HPV (THIN PREP ONLY)

O

Name: MARCIAL, MARICEL Q.
DOB: 01/21/1973

MRN: 00341329
Visit#: 16783980ACL-LU91612171

Gynecologic Cytology Consultation Report

Client: LU916 AMG IL/GYNE-ONCOLOGY

Date Specimen Collected: 06/19/12 Accession #: RG12-55154
Date Specimen Received: 06/19/12 Requisition
#: 7832300AM12171THINHPV
Date Reported: 6/26/2012 15:02

Cytologic Interpretation :

Negative for intraepithelial lesion or malignancy.

Satisfactory for evaluation. Presence of endocervical/transformation zone component.

Priya X Patel, CT (ASCP)

** Electronic Signature (PXP) 6/26/2012 15:02 **

Educational note: The Pap test is a screening test with a well-recognized false negative rate. The best means available to lower the false negative rate and to detect early cervical lesions is a Pap test at regular intervals. All ThinPrep Paps will be reviewed with the aid of the ThinPrep Imaging System, unless otherwise specified.

Patient: MARCIAL, MARICEL Q

EMRN: 00341329

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
-------------	---------------	--------------	-----------------------------

Clinical Information:

LMP: 6/15/12

Other Clinical Conditions: Previous Pap: Negative

ABN-N/A

DX: V72.31, ROUTINE GYNECOLOGICAL EXAMINATION

LMP: 6/15/12

ABNORMAL BLEEDING: N

POST-MENOPAUSAL: N

POST-PARTUM: N

PRE-MENOPAUSAL: Y

HISTORY OF COLPOSCOPY: N

SOURCE: ENDOCERVICAL: Y

SOURCE: VAGINAL: N

SOURCE: VULVAR: N

HISTORY OF CANCER: N

CONTRACEPTIVE HISTORY: N

DIAGNOSTIC: V72.31

HYSTERECTOMY: NO

PREVIOUS PAP: NEGATIVE

PREVIOUS PAP: LOW RISK (V76.2)

Specimen(s) Submitted:

Thin Prep HPV Reflex (E-Order)

ICD-9 Codes:

V72.31 V76.2

Fee Codes:

A: T-88175-IL

Performing Lab Location (Unless otherwise specified):

ACL Illinois Central Laboratory

5400 Pearl Street Rosemont, IL 60018

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date: 25Jan2012
Division: GENERAL INTERNAL MEDICINE
Location: NESSET INTERNAL MEDICINE
Billing Area: INT MED NESSET 140
Pt Ins: HMO HUMANA/ADVOCATE
Special Billing:
CRF#:

Billing Provider: CONLEY, MARK
Compliance Code:
Performing Provider: STERL, KARIN
Referring Provider:
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	0	Gen Exam

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	86762		RUBELLA		Zavala, Leslie
				ANTIBOD_86762		
Submitted	1	86765		RUBEOLA		Zavala, Leslie
				ANTIBODY_86765		
Submitted	1	86735		MUMPS		Zavala, Leslie
				ANTIBODY_86735		

Printed by: Powell, Anita

1

Date: 11/7/17 8:22PM

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession #: R001226269MUMG2012
Ordering Provider: STERL, KARIN
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 01/25/2012 7:00:00PM
Resulted: 01/27/2012 10:56:00AM
Verified By: STERL, KARIN
Auto Verify: N

MUMPS IGG (IMMUNE)

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
MUMPS IGG (IMMUNE)	2.20	OD RATIO	<0.91
<p>< OR = 0.90. Negative. No significant level of IgG antibody detected.</p> <p>0.91-1.09. Equivocal. Suggest repeat testing.</p> <p>> or = 1.10. Positive. Significant level of detectable IgG antibody.</p>			

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # R001226269RUBEL2012
Ordering Provider: STERL, KARIN
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 01/25/2012 7:00:00PM
Resulted: 01/26/2012 3:11:00AM
Verified By: STERL, KARIN
Auto Verify: N

RUBELLA ANTIBODY IGG

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
RUBELLA ANTIBODY, IGG	>500.0	UNITS/ML	>9.9
<5.0 Units/mL = Negative for IgG antibodies (Non Immune)			
5.0 to 9.9 Units/mL = Equivocal (Non Immune)			
>9.9 Units/mL = Immune			

Result does not represent an antibody titer.

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # R001226269MEAI2012
Ordering Provider: STERL, KARIN
Performing Location: ACL-WI Central Lab
8901 WEST LINCOLN AVENUE
WEST ALLIS, WI 53227

Collected: 01/25/2012 7:00:00PM
Resulted: 01/26/2012 10:17:00AM
Verified By: STERL, KARIN
Auto Verify: N

RUBEOLA IMMUNITY IGG

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
RUBEOLA IGG (IMMUNE)	5.57	OD RATIO	>1.09
0.90 or less OD Ratio is Negative for IgG antibodies (Not Immune).			
0.91 to 1.09 OD Ratio is Equivocal (Not Immune).			
1.10 or greater OD Ratio is Positive for IgG antibodies (Immune).			

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date: 30Dec2011
Division: GENERAL INTERNAL MEDICINE
Location: NESSET INTERNAL MEDICINE
Billing Area: INT MED NESSET 140
Pt Ins: HMO HUMANA/ADVOCATE
Special Billing:
CRF #:

Billing Provider: HOLMES, THOMAS
Compliance Code:
Performing Provider: STERL, KARIN
Referring Provider:
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	0	Gen Exam

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	83036		HGB, GLYCATED_83036		Zavala, Leslie

Printed by: Powell, Anita

1

Date: 11/7/17 8:22PM

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # R001193475GLYH2011
Ordering Provider: STERL, KARIN
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 12/30/2011 11:12:00AM
Resulted: 12/30/2011 7:49:00PM
Verified By: STERL, KARIN
Auto Verify: N

HEMOGLOBIN A1C GLYCOSYLATED

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
HEMOGLOBIN A1C GLYH	5.6	%	4.5-5.9
A1C% eAG mg/dL			
6.0 126			
6.5 140			
7.0 154			
7.5 169			
8.0 183			
8.5 197			
9.0 212			
9.5 226			
10.0 240			
NON DIABETIC	<6%		
EXCELLENT CONTROL	6-7%		
GOOD TO FAIR CONTROL	>7-8%		
SUBOPTIMAL GLYCEMIC CONTROL	>8%		

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # XR-11-0750106AMG
Ordering Provider: STERL, KARIN
Performing Location: AMG NESSET

Collected: 12/13/2011 5:56:00PM
Resulted: 12/13/2011 5:56:00PM
Verified By: STERL, KARIN
Auto Verify: N

XR CHEST PA, LATERAL 2V

Stage: Final

Result: 12/14/2011 11:06:00AM STERL, KARIN

Annotations: called pt and left voicemail. will recheck blood glucose as pt might not have been fasting for enough hours

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
XR CHEST PA, LATERAL 2V			

PA and lateral views of the chest demonstrate the lung fields to be free of infiltrates. There are no effusions. Heart is normal in size and contour. Pulmonary vascularity is not congested.

Impression: No acute cardiopulmonary disease radiographically.

**** F I N A L ****

Transcribed By: TP
12/14/11 0:15 am

Dictated By: GNEGY-MD, RICHARD

Electronically Reviewed and Approved By: GNEGY-MD, RICHARD 12/14/11
0:16 am

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date 13Dec2011 3:45PM
Provider: STBRL, KARIN (3483)
Dept: Int Med, 1775 Ballard-Nesset
Appt Loc: 1775 Ballard, Internal Med Nesset
For:
Appt No.: 16018877
Pt Ins: HMO HUMANA/ADVOCATE
Special Billing:
CRF #:

Billing Provider: CONLEY, MARK
Compliance Code:
Performing Provider: STBRL, KARIN
Referring Provider:
Division: GENERAL INTERNAL MEDICINE
Location: NESSET INTERNAL MEDICINE
Billing Area: INT MED NESSET 140
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	0	Gen Exam
	2	0	Abnl PPD

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	99395		Est Prev Med: Age 18-39		Zavala, Leslie

Printed by: Powell, Anita

1

Date 11/7/17 8:22PM

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

PCP Primary Care Note
12/13/2011 3:45PM

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

Chief Complaint

- Visit for: comprehensive medical evaluation

Chaperone

N/A.

Quality

No tobacco use. Alcohol use. Education: exercising regularly. Printed information given for activities. Influenza immunization. Discussion of regular exercise. No intervention and counseling on cessation of tobacco use

HPI

Pt is here for a physical exam. Has seasonal allergies, well controlled with Zyrtec. Has pain in her R shoulder, started taking Ibuprofen and the pain improved. Denies numbness and weakness in that arm. Had a poz PPD in 1994, CXR was normal. Will start school at Rush and she needs a CXR. Has a lump in her l breast, it has been stable for years, she sees Dr Dolan for this. PAP smear will be done at her gynecologists office. Last one was in 2003. Tetanus shot done in 2007. LMP Nov 24th, menstrual periods are regular.

ROS

Systemic: Energy level.

Head: No headache.

Cardiovascular: No chest pain or discomfort. Palpitations

Pulmonary: No cough and no wheezing.

Gastrointestinal: No vomiting, no diarrhea, and no constipation.

Active Problems

Breast Palpation Mass (611.72)

Neck Strain (847.0),

* post MVA, 12 Aug 2009

Palpitations (785.1).

Family Hx

Family history of Reported Family History Of Cancer, M with br ca
Diabetes mellitus.

Personal Hx

Alcohol: Not having considered quitting drinking, not getting angry when talked to about drinking, not drinking alcohol regularly, and feeling guilty about it, and not having a drink or two in the morning to get going.

Habits: Exercising regularly.

Denied Alcohol

Denied Drug Use

Never A Smoker

Denied Tobacco Use.

Allergies

Printed By: Anita Powell

1 of 3

11/7/17 8:22:58 PM

PCP Primary Care Note

Patient: MARICEL Q. MARCIAL
Encounter: Dec 13 2011 3:45PM

SSN: XXX-XX-7272
EMRN: 00341329

No Known Drug Allergy.

Current Meds

No Reported Medications;; RPT.

Vital Signs

Recorded by Paul,Elizabeth on 13 Dec 2011 04:06 PM

BP:114/68, RUE, Sitting,

HR: 80 b/min, R Radial, Regular,

Height: 64.500000 in, Weight: 143.250000 lb, BMI: 24.2 kg/m2,

BSA Calculated: 1.71 ,

BMI Calculated: 24.16.

Physical Exam

Vital Signs:

° Current vital signs reviewed.

General Appearance:

° Normal.

Neck:

° Normal.

Ears, Nose, Throat:

° ENT: normal.

Lymph Nodes:

° Normal.

Lungs:

° Normal.

Cardiovascular:

Auscultation: ° Normal.

Arterial Pulses: ° Equal bilaterally and normal.

Abdomen:

Auscultation: ° Abdominal auscultation revealed no abnormalities.

Palpation: ° Abdominal palpation revealed no abnormalities.

Skin:

° Normal.

Results

CBC WITH AUTOMATED DIFFERENTIAL 13 Dec 2011 11:01 AM

- WBC: 6.0 K/mL Reference Range: 4.2-11.0
- RBC: 4.29 mil/mL Reference Range: 4.00-5.20
- HEMOGLOBIN: 13.4 g/dl Reference Range: 12.0-15.5
- HEMATOCRIT: 39.2 % Reference Range: 36.0-45.6
- MCV: 91.4 fL Reference Range: 78.0-100.0
- MCH: 31.2 pg Reference Range: 26.0-34.0
- MCHC: 34.2 g/dl Reference Range: 32.0-36.5
- RDWCV: 12.4 % Reference Range: 11.0-15.0
- PLATELET: 248 K/mL Reference Range: 140-450
- NEU%: 65 % Reference Range: 33-69
- LYM%: 23 % Reference Range: 20-55
- MON%: 9 % Reference Range: 0-10
- EOS%: 3 % Reference Range: 0-6
- BASO%: 1 % Reference Range: 0-2
- NEU ABS: 3.9 K/mL Reference Range: 1.8-7.7
- LYM ABS: 1.4 K/mL Reference Range: 1.0-4.8
- MON ABS: 0.5 K/mL Reference Range: 0.3-0.9

Printed By: Anita Powell

2 of 3

11/7/17 8:22:58 PM

PCP Primary Care Note

Patient: MARICEL Q. MARCIAL
Encounter: Dec 13 2011 3:45PM

SSN: XXX-XX-7272
EMRN: 00341329

- EOS ABS: 0.2 K/mL Reference Range: 0.1-0.5
 - BASO ABS: 0.0 K/mL Reference Range: 0.0-0.3
 - SMEAR REVIEW: DNR Flag: N.
- CBC WITH AUTOMATED DIFFERENTIAL 13 Dec 2011 11:01 AM
- WBC: 6.0 K/mL Reference Range: 4.2-11.0
 - RBC: 4.29 mil/mL Reference Range: 4.00-5.20
 - HEMOGLOBIN: 13.4 g/dl Reference Range: 12.0-15.5
 - HEMATOCRIT: 39.2 % Reference Range: 36.0-45.6
 - MCV: 91.4 fL Reference Range: 78.0-100.0
 - MCH: 31.2 pg Reference Range: 26.0-34.0
 - MCHC: 34.2 g/dl Reference Range: 32.0-36.5
 - RDWCV: 12.4 % Reference Range: 11.0-15.0
 - PLATELET: 248 K/mL Reference Range: 140-450
 - NEU%: 65 % Reference Range: 33-69
 - LYM%: 23 % Reference Range: 20-55
 - MON%: 9 % Reference Range: 0-10
 - EOS%: 3 % Reference Range: 0-6
 - BASO%: 1 % Reference Range: 0-2
 - NEU ABS: 3.9 K/mL Reference Range: 1.8-7.7
 - LYM ABS: 1.4 K/mL Reference Range: 1.0-4.8
 - MON ABS: 0.5 K/mL Reference Range: 0.3-0.9
 - EOS ABS: 0.2 K/mL Reference Range: 0.1-0.5
 - BASO ABS: 0.0 K/mL Reference Range: 0.0-0.3
 - SMEAR REVIEW: DNR Flag: N.

Assessment

- Normal routine history and physical (V70.0)

Plan

- Annual physical exam
- CBC-WNL, CMP, TSH and lipid panel pending
 - will have PAP smear done at gynec's office
 - mammogram done in June-normal
 - received flu shot at work

Hx poz PPD

- will get CXR as pt needs it for school

Shoulder pain

- cont Ibuprofen TIDx2weeks and exercise

RV in 1 year

I discussed patient's case with the resident. I agree with resident's findings and plan as documented in today's note.

Signature

Electronically signed by : Elizabeth Paul RN, 12/13/2011 4:09 PM CST.
Electronically signed by : KARIN STERL M.D., 12/13/2011 5:09 PM CST.
Electronically signed by : MARK CONLEY D.O., 12/14/2011 8:49 AM CST.

Printed By: Anita Powell

3 of 3

11/7/17 8:22:59 PM

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # R001173611BPNL2011
Ordering Provider: STERL, KARIN
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 12/13/2011 11:01:00AM
Resulted: 12/13/2011 5:20:00PM
Verified By: STERL, KARIN
Auto Verify: N

BASIC METABOLIC PNL

Stage: Final

Result 12/14/2011 11:06:00A STERL, KARIN

Annotations: called pt and left voicemail. will recheck blood glucose as pt might not have been fasting for enough hours

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag</u>	<u>Reference Range</u>
SODIUM	139	mmol/L		135-145
POTASSIUM	4.4	mmol/L		3.4-5.1
CHLORIDE	103	mmol/L		98-107
CARBON DIOXIDE	26	mmol/L		21-32
ANION GAP	14	mmol/L		10-20
GLUCOSE	109	mg/dl	H	65-99
BUN	9	mg/dl	L	10-20
CREATININE	0.80	mg/dl		0.50-1.10
GFR EST. AFRICAN AMER	>60			>59
Units = mL/min/1.73m ²				
GFR EST. NONAFRI AMER	>60			>59
Units = mL/min/1.73m ²				
BUN/CREATININE RATIO	11			7-25
CALCIUM	9.0	mg/dl		8.4-10.2

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # R00117361 ILIPDPL2011
Ordering Provider: STERL, KARIN
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 12/13/2011 11:01:00AM
Resulted: 12/13/2011 5:20:00PM
Verified By: STERL, KARIN
Auto Verify: N

LIPID PNL

Stage: Final

Result 12/14/2011 11:06:00AM STERL, KARIN

Annotations: called pt and left voicemail. will recheck blood glucose as pt might not have been fasting for enough hours

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
FASTING STATUS	(NOTE)	hrs	
FASTING			
CHOLESTEROL	193	mg/dl	100-200
DESIRABLE	<200		
BORDERLINE HIGH	200-239		
HIGH	>=240		
HDL CHOLESTEROL	58	mg/dl	>39
LOW	<40		
HIGH	>=60		
TRIGLYCERIDES	65	mg/dl	<150
NORMAL	<150		
BORDERLINE HIGH	150-199		
HIGH	>200		
LDL CHOLESTEROL (CALCULATED)	122	mg/dl	<130
OPTIMAL	<100		
NEAR OPTIMAL	100-129		
BORDERLINE HIGH	130-159		
HIGH	160-189		
VERY HIGH	>=190		
NON-HDL CHOLESTEROL	135	mg/dl	
THERAPEUTIC TARGET			
CHD AND RISK EQUIVALENTS	<130		
MULTIPLE RISK FACTORS	<160		
0-1 RISK FACTORS	<190		

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Page 1 of 2

Patient: MARCIAL, MARICEL Q

EMRN: 00341329

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag</u>	<u>Reference Range</u>
CHOLESTEROL/HDL RATIO	3.3			<4.5

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Page 2 of 2

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # R001173611TSHR2011
Ordering Provider: STERL, KARIN
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 12/13/2011 11:01:00AM
Resulted: 12/13/2011 5:20:00PM
Verified By: STERL, KARIN
Auto Verify: N

TSH WITH REFLEX

Stage: Final

Result 12/14/2011 11:06:00AM STERL, KARIN

Annotations: called pt and left voicemail. will recheck blood glucose as pt might not have been fasting for enough hours

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
TSH	1.796	mcUnits/mL	0.350-5.000
Findings most consistent with euthyroid state, no additional testing suggested. TSH may be normal in patients with thyroid dysfunction and pituitary disease. Clinical correlation recommended. (Reflex TSH algorithm is not recommended in hospitalized patients. A variety of drugs, as well as serious acute and chronic illnesses may alter thyroid function tests. Commonly implicated drugs include glucocorticoids, dopamine, carbamazepine, iodine, amiodarone, lithium and heparin.)			

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession #: R001173611BCBA2011
Ordering Provider: STERL, KARIN
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 12/13/2011 11:01:00AM
Resulted: 12/13/2011 1:49:00PM
Verified By: STERL, KARIN
Auto Verify: N

CBC WITH AUTOMATED DIFFERENTIAL

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
WHITE BLOOD COUNT	6.0	K/mcL	4.2-11.0
RED BLL COUNT	4.29	mil/mcL	4.00-5.20
HEMOGLOBIN	13.4	g/dl	12.0-15.5
HEMATOCRIT	39.2	%	36.0-45.6
MEAN CORPUSCULAR VOLUME	91.4	fL	78.0-100.0
MEAN CORPUSCULAR HEMOGLOBIN	31.2	pg	26.0-34.0
MEAN CORPUSCULAR HGB CONC	34.2	g/dl	32.0-36.5
RDW-CV	12.4	%	11.0-15.0
PLATELET COUNT	248	K/mcL	140-450
NEU%	65	%	33-69
LYM%	23	%	20-55
MON%	9	%	0-10
EOS%	3	%	0-6
BASO%	1	%	0-2
NEU ABS	3.9	K/mcL	1.8-7.7
LYM ABS	1.4	K/mcL	1.0-4.8
MON ABS	0.5	K/mcL	0.3-0.9
EOS ABS	0.2	K/mcL	0.1-0.5
BASO ABS	0.0	K/mcL	0.0-0.3
SMEAR REVIEW	DNR		

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date: 13Dec2011
Division: GENERAL INTERNAL MEDICINE
Location: NESSET INTERNAL MEDICINE
Billing Area: INT MED NESSET 140
Pt Ins: HMO HUMANA/ADVOCATE
Special Billing:
CRF #:

Billing Provider: CONLEY, MARK
Compliance Code:
Performing Provider: STERL, KARIN
Referring Provider:
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	0	Gen Exam

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	85025		BLOOD CT, HG AND PLATELET CT AUTO & AUTO COMPLET_85025		Kopec, Katarzyna
Submitted	1	80048		BASIC METABOLIC PANELS_80048		Kopec, Katarzyna
Submitted	1	80061		LIPID PANEL_80061		Kopec, Katarzyna
Submitted	1	84443		THYROID STIMULATING HORMONE (TSH)_84443		Kopec, Katarzyna

Printed by: Powell, Anita

1

Date: 11/7/17 8:23PM

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

LGH_Breast Center Progress Note
04/18/2011 5:32PM

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

April 18, 2011

RE: MARICEL Q MARCIAL

The patient is a 38-year-old female gravida 0, para 0, LMP 04/04/2011 here for followup breast exam. The patient had bilateral mammogram performed on 04/04/2011 with a right breast ultrasound and both of these studies were unremarkable. There is no evidence of any suspicious lesions. The patient was reassured and informed of these findings. The patient continues to note an area of palpable thickening in the right breast which she has noted for at least 10 years and is unchanged. The patient does note that there is some cyclical change relative to her menstrual cycle. She does not take any hormones. No birth control pills. Her mother had DCIS diagnosed at age 54. She has a maternal second cousin who had breast cancer in her 40s and underwent apparently bilateral mastectomy. The patient has not had any breast biopsies or surgery here at Lutheran General. Remainder review of systems negative.

On exam she is afebrile, pulse of 68, respirations 18, blood pressure 119/67. HEENT is negative. Node survey is negative. Thyroid exam is normal. Lungs are clear. Cardiac exam is normal. Bilateral breast exam is performed sitting and supine. There are no dominant masses, skin changes, nipple discharge, or axillary adenopathy bilaterally. The area of concern in the upper outer aspect just lateral to the nipple areolar complex is fibrous tissue. There are no discrete masses by my exam and the patient also stated there has been no change in this area on self-exam for at least 10 years.

The patient did have a bilateral breast MRI in January 2009 which was also negative.

ASSESSMENT: This is a 38-year-old female with fibrocystic change. No worrisome or significant findings. The option of continued close followup versus the role of excisional biopsy was explained. The patient would like to avoid biopsy. The patient will continue close followup and if anything changes she will call us. Otherwise, we will

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1 of 2

11/7/17 8:23:11 PM

LGH_Breast Center Progress Note

Patient: MARICEL Q. MARCIAL
Encounter: Apr 18 2011 5:32PM

SSN: XXX-XX-7272
EMRN: 00341329

plan on seeing her back in 6 months for serial interval exam. Questions were answered. The patient expressed understanding. She will continue her primary care under direction of Dr. Mark Conley. We also reviewed with the patient the pros and cons of genetic consultation and the contact information was given for Dr. Booth and she will consider seeing them and reviewing her family history with them.

James Dolan, M.D.

MEDQ/790992

cc: Mark Conley, D.O.

Breast Center Progress Note - 1

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date 11Aug2009 12:00PM
Provider: CONLEY, MARK (1084)
Dept: Int Med, 1775 Ballard-Nesset
Appt Loc: 1775 Ballard, Internal Med Nesset
For:
Appt No.: 12522410
Pt Ins: HMO HUMANA/ADVOCATE
Special Billing:
CRF #:

Billing Provider: CONLEY, MARK
Compliance Code:
Performing Provider: CONLEY, MARK
Referring Provider:
Division: GENERAL INTERNAL MEDICINE
Location: NESSET INTERNAL MEDICINE
Billing Area: INT MED NESSET 140
Special Billing Date:

Diagnoses

Primary	#	Code	Description
Yes	1	0	Sprain cervical

Charges

Status	Units	Code	Mod	Description	Linked DX	Submitted by
Submitted	1	99213		Est Patient: Low Complexity		Zavala, Leslie

JMRP: J6 Medicare Administrative Contractor (MAC) National Government Services (NGS) (IL)

Printed by: Powell, Anita

1

Date: 11/7/17 8:23PM

**Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117**

**PCP Chronic Care Note
08/11/2009 12:00PM**

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

Chief Complaint

• follow up

HPI

In MVA on 8/9 on 190.
She was rear ended as she slowed for car in front of her.
Restrained driver
Neck and shoulder soreness two the three hours post MVA.
No head trauma.
No air bag deployment.
Felt as though she was hit twice.
Tension in the neck, mostly right.
No headache. No loss of arm strength or paresthesias.

Active Problems

Breast Palpation Mass (611.72)
Palpitations (785.1).

Family Hx

Family history of Reported Family History Of Cancer; M with br ea

Personal Hx

No Alcohol
No Drug Use
No Tobacco Use.

Allergies

No Known Drug Allergy.

Vital Signs

Recorded by rodrigueza on 11 Aug 2009 03:29 PM
BP.100/60, RUE, Sitting,
HR. 80 b/min, R Radial, Normal,
Weight. 141 lb.

Physical Exam

Vital signs:

° Current vital signs reviewed.

General appearance:

° Normal.

Head:

° Normal.

Neck:

° Normal no spinous process tenderness.

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1 of 2

11/7/17 8:23:18 PM

PCP Chronic Care Note

Patient: MARICEL Q. MARCIAL
Encounter: Aug 11 2009 12:00PM

SSN: XXX-XX-7272
EMRN: 00341329

Ears, Nose, Throat:

° ENT: normal.

Chest:

° Normal.

Lungs:

° Normal.

Cardiovascular system:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal.

Murmurs: ° No murmurs were heard.

Musculoskeletal system:

General/bilateral: • Musculoskeletal system: mild tenderness of the right trapezius.

Neurological:

Sensation: ° No sensory exam abnormalities were noted.

Motor: ° A motor exam demonstrated no dysfunction.

Reflexes: ° Normal.

Assessment

• Neck strain (847.0),

*post MVA; 12 Aug 2009

Plan

No neurologic findings.

No spinous process tenderness.

Apply heat.

OTC NSAID.

Cervical exercises explained.

Call if no better.

Signature

Signed By: Ana Rodriguez CMA; 08/11/2009 3:29 PM CST.

Signed By: MARK CONLEY D.O.; 08/12/2009 8:54 AM CST.

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

LGH_Breast Center Progress Note
12/15/2008 4:26PM

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

December 15, 2008

RE: MARICEL Q MARCIAL

HISTORY OF PRESENT ILLNESS: Patient is a 35-year-old female, gravida 0, para 0 with a recent bilateral mammogram that was obtained on 12/11/2008. There were some calcifications noted in the right breast and ultrasound was also performed which was negative. Her left breast was without significant worrisome or suspicious change. Patient also had an area of focal asymmetry in the right breast, middle lateral depth. MRI was recommended after clinical breast exam. Patient also notes an area of nodularity which she had present since at least the year 2000 just lateral to her nipple areolar complex. She apparently did see Dr. Peckler in the past and excision was discussed, however, this was not performed. Patient has noted minimal to no change in this area since 2000. She has no other complaints. No nipple discharge, no tenderness. No redness, no thickening of the skin or dimpling. She is gravida 0, para 0. Her LMP was 12/03/2008. She does not use birth control pills.

PAST SURGICAL HISTORY: She had no prior surgery.

FAMILY HISTORY: Mother was diagnosed at age 54 with a right breast DCIS. She is status post mastectomy, no chemotherapy or radiation. She has one sister alive and well. She has a maternal second cousin who had a bilateral mastectomy when she was in her 40s. She has a maternal aunt who died of lung cancer who was a smoker. Paternal grandfather had prostate cancer and a paternal aunt had lung cancer and was also a smoker. The area in the right breast has been present again since 2000 with slight change during her menstrual cycle.

REVIEW OF SYSTEMS: Otherwise negative.

MEDICATIONS: She takes no current medications.

ALLERGIES: She has no known drug allergies.

Printed By: Anita Powell

1 of 2

11/7/17 8:23:20 PM

LGH_Breast Center Progress Note

Patient: MARICEL Q. MARCIAL
Encounter: Dec 15 2008 4:26PM

SSN: XXX-XX-7272
EMRN: 00341329

PHYSICAL EXAMINATION: She 65 inches tall. Weight 137. HEENT: Negative. Node survey: Negative. Lungs: Clear. Cardiac: Sounds are normal. Neck: Thyroid exam is normal. There is no suspicious supraclavicular adenopathy or axonopathy bilaterally. Breasts: Bilateral breast exam was performed sitting and supine. There are no discrete masses bilaterally. The area of concern feels like prominent glandular or fibrous tissue by my exam, is very subtle and no discrete masses were seen. Patient does have dense breasts, however, bilaterally. There are no obvious or suspicious masses.

PLAN: We did inform the patient of our findings. We recommended she have a consult with Dr. Carol Booth for genetic counseling and assessment for possible BRCA I and II testing. We did give her an order for bilateral breast MRI. She will return to see us in two to three weeks or sooner if any problems occur. We did discuss followup with serial mammogram, ultrasound and MRI pending the MRI result. The role of excisional biopsy based on the MRI findings was also reviewed. Patient expressed understanding. She will also follow up Dr. Daniel Pesch for her gynecologic continued care.

Breast Center Progress Note - 1

James R. Dolan, M.D.

MEDQ/273304

cc. Daniel Pesch, M.D.

Breast Center Progress Note - 2

Printed By: Anita Powell

2 of 2

11/7/17 8:23 20 PM

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date 06Aug2008 10:45AM
Provider: ZZZPESCH,DANIEL (S252)
Dept: O/B Residency Program
Appt Loc: OBR
For:
Appt No.: 11242205
Pt Ins: PPO PRIVATE HEALTHCARE SYSTEMS
Special Billing:
CRF #:

Billing Provider: ZZZPESCH, DANIEL
Compliance Code:
Performing Provider: ZZZPESCH, DANIEL
Referring Provider:
Division: OBSTETRICS AND GYNECOLOGY
Location: OB GYN RESIDENTS YACKEMAN
Billing Area: OB/GYN RESIDENCY CLINIC CC160
Special Billing Date:

Diagnoses

<u>PRIMARY</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	0	Breast lump

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	99204		New Patient: Mod Complexity		ZZZPESCH, DANIEL

LMRP: J6 Medicare Administrative Contractor (MAC) National Government Services (NGS) (IL)

Printed by: Powell, Anita

1

Date: 11/7/17 8:23PM

Advocate Medical Group
AMG-Sykes
2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Gynecologic Visit
08/06/2008 10:45AM

Patient:
MARICEL MARCIAL
2616 N SPAULDING APT 3
CHICAGO, IL 60647

MRN: 00341329
DOB: 01/21/1973
Phone: (847) 809-5669

Chaperone
New pt here for annual exam and pap.
August 6, 2008

Chaperone : Declined.

Vital Signs

Recorded by martinezg on 06 Aug 2008 10:53 AM
BP: 110/64,
Weight: 145.5 lb.

Vitals 2

G: 0 P: 0000
LMP: 7/4/08
LAST PAP: 2 years ago
METHOD OF BC: none.

Immunizations

Reviewed.

Personal Hx

Behavioral history: No tobacco use.
Alcohol: No consumption of alcohol.
Drug use: Not using drugs.
Reviewed.

Current Meds

Reviewed.

Allergies

No Known Drug Allergy.

PGH

No menses, No abnormal paps.

PMH

Reviewed.

PSH

Reviewed.

Family Hx

Reviewed

Cancer: M with br ca.

Chief Complaint

- Breast symptoms: Has known breast mass stable for many years and FII of br ca
- No genitourinary symptoms

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1 of 2

11/7/17 8:23:24 PM

Gynecologic Visit

Patient: MARICEL Q. MARCIAL
Encounter: Aug 6 2008 10:45AM

SSN: XXX-XX-7272
EMRN: 00341329

ROS

Systemic symptoms: Not feeling tired (fatigue). No recent weight change.

Cardiovascular symptoms: No cardiovascular symptoms.

Pulmonary symptoms: No pulmonary symptoms.

Gastrointestinal symptoms: No gastrointestinal symptoms.

Physical Exam

Head:

° Normal.

Neck:

° Normal.

Lymph Nodes:

° Normal.

Chest:

° Normal.

Breasts:

General/bilateral.

• Breasts: RUQ quadrant mass 1cm smooth mobile.

Lungs:

° Normal.

Cardiovascular system:

° Normal.

Abdomen:

° Normal.

Gyne Exam

The vagina was normal. Cervix normal and showed no lesion. The uterus was normal and the uterine adnexae were normal.

Assessment

• A breast mass was found (611.72)

Orders

PAP SMEAR, THIN PREP.

Follow-up visit in 1 year.

MA MAMMOGRAM SCREEN BIL.

Plan

The patient desires definitive information regarding testing for breast Ca. Recommended consult with Dr. Delan regarding ongoing screening. Diet, exercise and MVI/Ca use discussed. SBE reviewed.

Signature

Signed By: Gesalle Martinez ; 08/06/2008 10:53 AM CST.

Signed By: DANIEL PESCH M.D.; 08/06/2008 1:27 PM CST.

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # IOG08-71754
Ordering Provider: PESCH, DANIEL
Performing Location: ACL

Collected: 08/06/2008 12:00:00AM
Resulted: 08/07/2008 4:18:00AM
Verified By: ZZZPESCH, DANIEL
Auto Verify: N

CYTOLOGY NON-GYN

Stage: Final

Result 08/12/2008 10:27:00AM Zidek, Patricia
Annotations: ncs

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
-------------	---------------	--------------	-----------------------------

CYTOLOGY NON-GYN

ICL CYTOLOGY REPORT

Client: LU905 AMG/OB GYNE-YACTMAN

Date Specimen Collected: 08/06/08	Accession #: IOG08-71754
Date Specimen Received: 08/07/08	Requisition #:
273746AM08210THINPREP	
Date Reported: 8/10/2008 21:10	

Specimen(s) Submitted: Thin Prep-Imager(E-Order), Site not specified.

Cytologic Diagnosis :

Thin Prep-Imager(E-Order), Site not specified.:

Statement of Adequacy:
Satisfactory for evaluation. Presence of endocervical/transformation zone component.

Descriptive Interpretation:
Negative for intraepithelial lesion or malignancy.

Comment: The Pap smear is not a diagnostic test. It is a screening test with an inherent false negative rate in the range of 5-10%. Annual Pap smears are the best means available to lower this false negative rate and to detect early cervical cancer. Please share this information with your patient.

Lakshmi S Yarlagadda

Printed by: Powell, Anita | 11/07/2017 8:23:00PM

Page 1 of 2

Patient: MARCIAL, MARICEL Q

EMRN: 00341329

Test

Result

Units

Flag Reference Range

** Electronic Signature (LSY) **

LMP: 07/04/2008

Fee Codes: A: 88175

Printed by: Powell, Anita | 11/07/2017 8:23:00PM

Page 2 of 2

CONFIDENTIAL

AMG 000095

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession #: R000011476CBA2007
Ordering Provider: DECKER, SHARON
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 10/29/2007 8:25:00AM
Resulted: 10/29/2007 8:25:00AM
Verified By: DECKER, SHARON
Auto Verify: N

CBC WITH AUTOMATED DIFFERENTIAL

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
WHITE BLOOD COUNT	8.4		4.2-11.0
RED CELL COUNT	4.44		4.00-5.20
HEMOGLOBIN	13.9		12.0-15.5
HEMATOCRIT	41.7		36.0-45.6
MEAN CORPUSCULAR VOLUME	93.9		78.0-100.0
MEAN CORPUSCULAR HEMOGLOBIN	31.3		26.0-34.0
MEAN CORPUSCULAR HGB CONC	33.3		32.0-36.5
RDW-CV	12.5		11.0-15.0
PLATELET COUNT	254		140-450
NEU%	66		33-69
LYM%	21		20-55
MON%	9		0-10
EOS%	3		0-6
BASO%	0		0-2
NEU ABS	5.6		1.8-7.7
LYM ABS	1.8		1.0-4.8
MON ABS	0.8		0.3-0.9
EOS ABS	0.3		0.1-0.5
BASO ABS	0.0		0.0-0.3
SMEAR REVIEW	DNR		

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession #: R000011476CPNL2007
Ordering Provider: DECKER, SHARON
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 10/29/2007 8:25:00AM
Resulted: 10/29/2007 8:25:00AM
Verified By: DECKER, SHARON
Auto Verify: N

COMP METABOLIC PNL

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag</u>	<u>Reference Range</u>
SODIUM	140			135-145
POTASSIUM	4.4			3.5-5.0
CHLORIDE	102			98-107
CARBON DIOXIDE	28			22-30
ANION GAP	10			8-16
GLUCOSE	98			65-99
BUN	8		L	10-20
CREATININE	0.8			0.6-1.1
GFR EST AFRICAN AMER	>60			>60
GFR EST NONAFRI AMER	>60			>60
BUN/CREATININE RATIO	10			7-25
BILIRUBIN TOTAL	0.4			<1.4
GOT/AST	22			8-39
ALKALINE PHOSPHATASE	55			38-126
ALBUMIN	4.5			3.5-5.0
TOTAL PROTEIN	7.6			6.0-8.2
GLOBULIN (CALCULATED)	3.1			2.0-4.0
A/G RATIO	1.5			1.0-2.4
CALCIUM	9.4			8.4-10.2
GPT/ALT	17			9-52

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
EMRN: 00341329
OMRN: 00341329
DOB: 21Jan1973

Encounter Form

Encounter Date: 29Oct2007
Division: GENERAL INTERNAL MEDICINE
Location: NESSET INTERNAL MEDICINE
Billing Area: INT MED NESSET 140
Pt Ins: PPO PRIVATE HEALTHCARE SYSTEMS
Special Billing:
CRF #:

Billing Provider: CONLEY, MARK
Compliance Code:
Performing Provider: DECKER, SHARON
Referring Provider:
Special Billing Date:

Diagnoses

<u>Primary</u>	<u>#</u>	<u>Code</u>	<u>Description</u>
Yes	1	0	Palpitations

Charges

<u>Status</u>	<u>Units</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Linked DX</u>	<u>Submitted by</u>
Submitted	1	80061		LIPID PANEL_80061		George, Blessy
				LMRP: J6 Medicare Administrative Contractor (MAC) National Government Services (NGS) (IL)		
Submitted	1	80053		COMPREHENSIVE METABOLIC PANEL_80053		George, Blessy
				LMRP: J6 Medicare Administrative Contractor (MAC) National Government Services (NGS) (IL)		
Submitted	1	85025		BLOOD CT, Hg AND PLATELET CT AUTO & AUTO COMPLT_85025		George, Blessy
				LMRP: J6 Medicare Administrative Contractor (MAC) National Government Services (NGS) (IL)		
Submitted	1	84443		THYROID STIMULATING HORMONE (TSH)_84443		George, Blessy
				LMRP: J6 Medicare Administrative Contractor (MAC) National Government Services (NGS) (IL)		

Printed by: Powell, Anita

1

Date: 11/7/17 8:23PM

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # R000011476LIPDPL2007
Ordering Provider: DECKER, SHARON
Performing Location: ACL CENTRAL LAB II.
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 10/29/2007 8:25:00AM
Resulted: 10/29/2007 8:25:00AM
Verified By: DECKER, SHARON
Auto Verify: N

LIPID PNL

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
FASTING STATUS	12.0		
CHOLESTEROL	193		100-200
Item Annotations 10/29/2007 4:39:00PM			
DESIRABLE	<200		
BORDERLINE HIGH	200-239		
HIGH	>=240		

HDL CHOLESTEROL	49		>39
Item Annotations 10/29/2007 4:39:00PM			
LOW	<40		
HIGH	>=60		

TRIGLYCERIDES	98		<150
LDL CHOLESTEROL (CALCULATED)	124		<130
Item Annotations 10/29/2007 4:39:00PM			
OPTIMAL	<100		
NEAR OPTIMAL	100-129		
BORDERLINE HIGH	130-159		
HIGH	160-189		
VERY HIGH	>=190		

NON-HDL CHOLESTEROL	144		
Item Annotations 10/29/2007 4:39:00PM			
THERAPEUTIC TARGET			
CHD AND RISK EQUIVALENTS	<130		
MULTIPLE RISK FACTORS	<160		
0-1 RISK FACTORS	<190		

CHOLESTEROL/HDL RATIO	3.9		<4.5

AMG-Sykes

2545 S. Martin Luther King Drive
Chicago, IL 60616
(312) 842-7117

Patient: MARCIAL, MARICEL Q
2616 N SPAULDING APT 3
CHICAGO, IL 60647

Age/Sex/DOB: 44 yrs F 21-Jan-1973
EMRN: 00341329
OMRN: 00341329
Home: (847) 809-5669
Work: (847) 723-0122

Results

Lab Accession # R000011476TSHR2007
Ordering Provider: DECKER, SHARON
Performing Location: ACL CENTRAL LAB IL
5400 PEARL ST
ROSEMONT, IL 60018-5320

Collected: 10/29/2007 8:25:00AM
Resulted: 10/29/2007 8:25:00AM
Verified By: DECKER, SHARON
Auto Verify: N

TSH WITH REFLEX

Stage: Final

<u>Test</u>	<u>Result</u>	<u>Units</u>	<u>Flag Reference Range</u>
TSH	2.84		0.35-5.00
Item Annotations 10/29/2007 5:51:00PM Findings most consistent with euthyroid state, no additional testing suggested. TSH may be normal in patients with thyroid dysfunction and pituitary disease. Clinical correlation recommended. (Reflex TSH algorithm is not recommended in hospitalized patients. A variety of drugs, as well as serious acute and chronic illnesses may alter thyroid function tests. Commonly implicated drugs include glucocorticoids, dopamine, carbamazepine, iodine, amiodarone, lithium and heparin.)			

EXHIBIT

A25

Psychiatric distress and symptoms of PTSD among victims of bullying at work

STIG BERGE MATTHIESEN & STÅLE EINARSEN

*Division of Work and Organisational Psychology, Department of Psychosocial Science,
University of Bergen, Christiesgate 12, N-5015 Bergen, Norway*

ABSTRACT *Distress and symptoms of Post-Traumatic Stress Disorder (PTSD) were investigated among targets of experienced bullying at work, that is, the exposure to persistent or recurrent oppressive, offensive, abusive behaviour where the aggressor may be a superior or a colleague. The participants in the present study were all recruited from two associations of bullied victims (n = 102, response rate = 57%). A high level of distress and symptoms of PTSD was revealed in the sample, both according to recommended cut point scores for HSCL-25, PTSS-10 and IES-R, and when comparing the sample with traumatised samples. Three out of four victims reported an HSCL-25 level higher than the recommended threshold for psychiatric disease. Sixty and 63% of the sample reported a high level of IES intrusion and IES avoidance, correspondingly. The level of bullying, operationalised as the frequency of negative acts the individual had been exposed to at work, showed a stronger interconnection with distress and PTSD than a more unspecified, subjective measure of bullying, as well as the time since the bullying took place and the duration of the bullying episode. Those still being pestered reported a higher level of distress and PTSD than victims in which the bullying episodes were terminated more than 1 year ago, but the findings were somewhat mixed. Positive affectivity (PA) and especially negative affectivity (NA) contributed significantly to the explained variance of distress and PTSD in various regression analysis models, but did not interact with measures of bullying. Nor were mediator effects found between bullying, PA/NA and traumatic stress reactions. Implications of the findings are discussed.*

During the last decade there has been a growing awareness of the detrimental effects on employee health and well-being caused by exposure to bullying and non-sexual harassment in the workplace (Einarsen, 1999; Einarsen *et al.*, 2003; Hoel *et al.*, 1999). Although studied by the use of many different concepts, such as 'emotional abuse at work' (Keasly, 1998), 'harassment at work' (Brodsky, 1976; Einarsen & Raknes, 1997), 'bullying at work' (Vartia, 1996), 'mistreatment' (Spratlen, 1995), 'mobbing' (Leymann, 1996; Zapf *et al.*, 1996), 'workplace aggression' (Baron & Neuman, 1996) or as 'workplace incivility' (Andersson & Pearson, 1999), comparable conclusions seem to be reached. Exposure to systematic and long-lasting

verbal, non-physical, and non-sexual, abusive and aggressive behaviour at the workplace may cause a host of negative health effects in the target. Although single acts of aggression and harassment do occur fairly often in everyday interaction, they seem to be associated with severe health problems when occurring on a regular basis (Einarsen & Raknes, 1997; Leymann, 1987). Bullying at work is claimed to be an extreme form of social stress at work (Zapf *et al.*, 1996). It is referred to as a more crippling and devastating problem for employees than all other work-related stressors put together (Wilson, 1991).

Bullying can be described as a certain subset of conflicts (Zapf & Gross, 2001), and may be defined as the exposure to persistent or recurrent oppressive, offensive, abusive, intimidating, malicious, or insulting behaviour by a superior or a colleague. Feelings of being victimised from bullying at work seem to be associated with the experience of (a) bullying behaviours being intentional, (b) a lack of opportunities to evade it, and (c) these behaviours or sanctions as unfair or over-dimensioned (Matthiesen *et al.*, 2003). To be a victim of intentional and systematic psychological harm by another person, real or perceived, seems to produce severe emotional reactions such as fear, anxiety, helplessness, depression and shock (Mikkelsen & Einarsen, 2002a,b). These reactions seem to be especially pronounced if the perpetrator is in a position of power or the situation is an unavoidable or inescapable one (Einarsen, 1999; Niedl, 1996). The workplace seems to be a setting where people are especially vulnerable when facing aggression, abuse, or harassment (Einarsen & Raknes, 1997). Victimisation, such as exposure to intense bullying at work, may change the individual's perceptions of their work-environment and life in general to one of threat, danger, insecurity and self-questioning (cf. Janoff-Bulman, 1992), which may result in pervasive emotional, psychosomatic and psychiatric problems (Leymann, 1990a).

In an interview study among 30 Irish victims, O'Moore and associates found that all subjects reported anxiety, irritability, feelings of depression and paranoia as a consequence of experiences of bullying at work (O'Moore *et al.*, 1998). Also very common were symptoms like mood swings, feelings of helplessness, a lowered self-esteem, and a range of physical symptoms. Clinical observations of victims of harassment at work have also shown other grave effects such as social isolation, social maladjustment, psychosomatic illnesses, depressions, helplessness, anger, anxiety, and despair (Leymann, 1990a). A study among a representative sample of Norwegian assistant nurses showed a significant relationship between exposure to on-going workplace harassment and an elevated level of burn-out, as well as a lowered job satisfaction and a lowered psychological well-being (Einarsen *et al.*, 1998).

On the basis of clinical observations and interviews with American victims of work harassment, Brodsky (1976) identified three patterns of effects on the victims. Some expressed their reaction by developing vague physical symptoms such as weakness, loss of strength, chronic fatigue, pains and various aches. Others reacted with depression and related symptoms such as impotence, lack of self-esteem, and sleeplessness. A third group reacted with psychological symptoms such as hostility,

hypersensitivity, memory problems, feelings of victimisation, nervousness, and the avoidance of social contact.

In view of the particular symptom constellation presented above, it has been argued that many victims of long term bullying at work may in fact suffer from Post-Traumatic Stress Disorder (PTSD) (Björkqvist *et al.*, 1994; Einarsen & Hellestøy, 1998; Leymann, 1992). In a Finnish study of 350 university employees, 19 persons subjected to victimisation by harassment were interviewed as a follow-up study (Björkqvist *et al.*, 1994). The victims experienced high levels of insomnia, various nervous symptoms such as anxiety, depression and aggression, melancholy, apathy, lack of concentration and socio-phobia, leading the authors to conclude that these victims portrayed symptoms reminiscent of PTSD. In his 1992 report, the Swedish psychiatrist Heinz Leymann argued that PTSD probably was the correct diagnosis for approximately 95% of a representative sample of 350 victims of bullying at work (Leymann, 1992).

A host of studies (see e.g. Creamer, 2000) have suggested that victimisation caused by the aggressive and violent behaviour of other fellow human beings may produce high levels of distress and symptoms of post-traumatic stress even long after the event actually happened. Studies also suggest that psychological or physical abuse seems to be at least as traumatising as for example physical and criminal forms of violence. Experiencing sexual assault made a larger impact on PTSD symptomatology than combat exposure, according to a study of 160 army women after returning from the Persian Gulf (Wolfe *et al.*, 1998). In another investigation, 100 victims of harassment by stalking were interviewed to assess the impact of the experience on their psychological, social, and interpersonal functioning (Pathe & Mullen, 1997). The majority of the victims were subjected to multiple forms of harassment such as being followed, repeatedly approached, and bombarded with letters and telephone calls for periods varying from 1 month to 20 years. Threats were perceived by 58%, whereas 34% were physically or sexually assaulted. Increased levels of anxiety were reported by 83%. Intrusive recollections and flashbacks were reported by 55%, while nightmares, appetite disturbances, and depressed mood were commonly experienced. The criteria for a diagnosis of Post-Traumatic Stress Disorder (PTSD) were fulfilled in 37% of the cases.

Fontana and Rosenheck (1998) studied the relative impact of stress from military duty and exposure to sexual harassment on the development of PTSD among 327 female veterans. Sexual abuse and harassment were almost four times as influential in the development of PTSD compared to other kinds of duty-related stress. Using a liberal cutoff score, Vitanza *et al.* (1995) diagnosed 73% of a group of psychologically abused women as having severe symptoms of PTSD. A Swedish study of PTSD in a group of 64 victims attending a rehabilitation programme for victims of bullying at work revealed that most of these victims were troubled with intrusive thoughts and avoidance reactions (Leymann & Gustavson, 1996). A Danish study of 118 bullied victims found that 76% portrayed symptoms indicating post-traumatic disorder (Mikkelsen & Einarsen, 2002a). Interpersonal conflicts in general may also be linked to PTSD symptoms. In a

Canadian study of 51 emergency personnel, a significant relationship was found between the level of interpersonal conflicts, and symptoms of PTSD (Laposa *et al.*, 2003).

Only a few studies (Leymann & Gustavson, 1996; Mikkelsen & Einarsen, 2002a) have been published on the relationship between exposure to bullying and symptoms of PTSD using a community sample. The aim of community studies is to assess specific disorders, in this case symptoms of post-traumatic stress, among a specified population, regardless of whether they have sought treatment or not (Schlenger *et al.*, 1997). The aim of the present study is therefore to examine the level of psychiatric symptoms and symptoms of PTSD among former and current victims of bullying at work, who has not necessarily sought medical or psychological treatment.

The literature on post-traumatic stress focus primarily on factors such as life-threatening menaces, object loss, physical harm and how hideous the critical incident turned out to be, as the main risk elements in development of PTSD (Davidson & Foa, 1993). This notion is however somewhat different from Dahl and his colleagues (Dahl *et al.*, 1994), who claim that Post-Traumatic Stress Disorder evolves if an event is perceived as threatening, scaring or awful, beyond a certain level. The risk of PTSD is claimed to increase if the incident(s) are prolonged, especially if adequate leadership is non-existent or social connections are lacking. Traumatic episodes connected to man-made aggressive acts (injustice, assaults, harassment) are argued to pose a greater risk than to incidents caused by accidents or disasters (Dahl *et al.*, 1994). A study of post-traumatic stress among women abused by their husbands concluded that psychological abuse even in rather subtle forms seems to produce clear cut symptoms of PTSD (Vitanza *et al.*, 1995). On the basis of case studies, Scott and Stradling (1994) argue that enduring psychosocial stress in the absence of one single acute and dramatic trauma may produce full symptomatology of PTSD.

In a theoretical framework of trauma at work, Williams (1993) argues that individual variables in personality and coping styles may have some overlap with PTSD as in regard to emotional distress. Although the causal relationship between individual differences and victimisation from bullying is a debatable one (Einarsen, 1999, 2000; Leymann, 1990a, 1996), victims of bullying at work do differ from non-bullied workers on a range of factors. For instance, Vartia (1996) found a high level of negative affectivity among a group of Finnish victims of bullying at work, while Zapf (1999) found German victims of bullying to be high on negative and low on positive affectivity compared to a control group. Experiences of negative social interactions in general seems to be associated with an increase in negative affectivity as well as low self-esteem and many dysfunctional attitudes (Lakey *et al.*, 1994). While Zapf (1999) argues that these characteristic may have caused bullying in the first place, other researchers (Mikkelsen & Einarsen, 2002b) claim that negative affectivity acts as a mediator and thus accounts for the relation between the victimisation and symptomatology by explaining how bullying takes on a psychological meaning. In a study of battered women the relationship between exposure to abuse and PTSD to a certain degree depended on vulnerability factors of

psychological dysfunctions such as cognitive failure and private self-consciousness (Saunders, 1994). The former is defined as the tendency to have perception and memory failures as well as engaging in misdirected action, while the latter refers to people who tend toward a self-analysis manner, focusing on their own perceptions, feelings and thoughts. Both concepts are considered to result from the excessive worry and anxiety caused by a highly threatening situation, hence they may be seen as partial mediators of the relationship between the experience of abuse and the evolving post-traumatic stress symptoms.

In the present study we will include the concepts of negative and positive affectivity as such possible mediating factors. Research has demonstrated those two independent dispositional variables to comprise the dominant factors of emotional experience (Watson, 1988). Negative affectivity (NA) is seen as a general factor of subjective distress and comprises a broad range of aversive mood states, including distress, nervousness, fear, anger and guilt. Individuals high in negative affectivity often focus on the negative sides of life and tend to have negative views of themselves, other people and the world in general. Positive affectivity (PA) reflects one's level of pleasurable engagement with the environment. High PA is composed of terms reflecting enthusiasm, energy, mental alertness and determination (e.g. excited, active, attentive, determined). Low PA is best defined by descriptors reflecting fatigue and depression (e.g. sluggish, sad). Positive and negative affectivity correspond roughly with the dominant factors extraversion and anxiety/neuroticism (Watson *et al.*, 1988).

The idea followed in many studies of work-related stress is that the tendency to experience positive and negative affect represents a stable, dispositional trait which may confound relationships between stressors and strain (Watson & Clark, 1984). However, exposure to bullying may also justify, enhance or even create a negative world-view and a negative emotional state, as proposed by the framework presented by Janoff-Bulman (1992). The core problem of bullying at work is that it undermines the target's sense of being a valuable and competent person living in a safe and caring environment (Keasly *et al.*, 1997; Leymann, 1990a). Distressed and dissatisfied with themselves, victims may focus on and magnify potential threats from their surroundings. Enhanced levels of state negative affectivity, as well as a lowered state of positive affect, may then initiate increased use of maladaptive coping strategies in turn causing higher levels of reported psychological symptoms and psychosomatic complaints (Costa & McCrae, 1980). Evidence that major stressful life events may increase symptomatology by increasing negative evaluations of others and self has been presented by Lakey and Edmundson (1993) and may easily be derived from the work of Janoff-Bulman (1992) as proposed by Mikkelsen and Einarsen (2002a). The aim of this study is to examine the level of psychiatric symptoms and symptoms of PTSD among current and former victims of bullying at work using a community sample. Second, we inquire how the PTSD symptoms relate to the kinds of bullying experienced by the victim and the duration of and time since the termination of the bullying. And third, we examine the role of state negative and positive affectivity as possible mediators or moderators in this stressor-strain relationship.

Method*Procedure*

The 102 participants in the study were recruited among members of two Norwegian national associations against bullying at work. In total, 180 victims of on-going or prior exposure to bullying at work were members of these associations, by the onset of the survey. They all got a survey questionnaire, distributed by the two associations (by mail). Attached to the questionnaire was a letter of recommendation from the heads of the associations. The questionnaires were anonymously returned directly to the researchers.

Subjects

Mean age of the sample was 51.6 years (range 30–74 years). Seventy-four percent of the sample were women. The major part of the participants worked or had worked in administrative or clerical jobs (38%), health services (28%), or education (13%). Only a limited part of the sample were in fact still employed (33%), whereas 17% were on sick-leave, 12% were unemployed (the unemployment rate in Norway was only some 3% at that particular time) and 10% had retired. In addition, one out of four (26%) were disabled pensioners. The sample had a high educational level, where 60% had a university degrees or college degree, mostly on an undergraduate level. Sixty-three percent of the respondents had been exposed to bullying for a period of 2 years or more. Almost one in four (22%) were still exposed to bullying, or the bullying took place less than 6 years ago (6%) when the survey was carried out. Almost one in three (30%) were hit by bullying more than 5 years ago. The most frequent kinds of bullying reported were ostracism (social isolation), being devaluated, holding back information, calumny, and frequent attacks or criticism against one's person.

Instruments

Bullying was measured in two ways. First, the following definition of workplace bullying was introduced to the respondents:

‘Bullying takes place when one or more persons systematically and over time feel that they have been subjected to negative treatment on the part of one or more persons, in a situation in which the person(s) exposed to the treatment have difficulty in defending themselves against them. It is not bullying when two equal strong opponents are in conflict with each other’ (Einarsen *et al.*, 1994).

Following this, the respondents were asked, ‘Have you been exposed to bullying at work?’ with three response alternatives (no, yes to some extent, and yes to a great extent). A quantitative measure of bullying, the Norwegian version of the 22-item

Negative Acts Questionnaire (NAQ; Einarsen & Raknes, 1997; Einarsen *et al.*, 1994), was also used. The NAQ consists of 22 items referring to specific kinds of bullying behaviours, such as exposure to excessive teasing, insulting remarks, social exclusion, verbal abuse, threats of being fired or redundant, and slanders or rumours about oneself. The respondents were asked if they had been exposed to any of these behaviours during the time they were targets of bullying, with the following response alternatives: never, occasionally, weekly, or daily.

Factor analysis has earlier revealed that the NAQ scale consists of two distinct subfactors, which were labelled 'personal derogation' and 'work-related harassment' (Einarsen & Raknes, 1997). In the present study, however, the NAQ score of each person was summed up to a single total measure of the intensity of the experienced bullying behaviours. Cronbach's alpha for NAQ was found to be 0.85.

Symptoms of post-traumatic stress were measured by the Impact of Event Scale, IES-R, the 22-item version (Weiss & Marmar, 1997), and the Post-Traumatic Stress Scale, PTSS-10 (Raphael *et al.*, 1989). The Impact of Event Scale Revised is a 22-item scale assessing three dimensions of symptoms often reported after trauma. The intrusion dimension consists of symptoms like intrusive memories, thoughts and emotions. The avoidance dimension measures symptoms related to avoiding memories and places, as well as denial. The newly added third dimension of the scale reflects hyperarousal, a strong kind of mental and bodily alertness. The four categories of IES was scored as 0, 1, 3, 5 according to standard scoring procedures (Horowitz, 1979; Weiss & Marmar, 1997). Cronbach alpha for the three subscales was found to be 0.81, 0.90 and 0.82, respectively. Horowitz (1979) divides the scores of IES (both intrusion and avoidance subscales) into three groups, with low, moderate and high level of post-traumatic stress (with respectively 0–9 points, 9–19 points, and 20 or more stress points). The cut point scoring procedures for the IES were applied, since IES-R does not have established separate cut point scores for the three subscales. In addition, the three subscales of IES were summed up to a single measure of post-traumatic stress. Here, a cut point threshold of 35 was applied, in line with Neal and associates (Neal *et al.*, 1994). Cronbach's alpha for the overall summed up scale was 0.94.

The PTSS-10 is a questionnaire assessing 10 common symptoms of PTSD (Raphael *et al.*, 1989). The measure range is from 1 (never/seldom) to 7 (very often). Cronbach's alpha was found to be 0.91 in the present study. Raphael *et al.* operationalise PTSD to be a PTSS-10 score of four or more on at least four items.

Psychiatric symptoms was measured by the Hopkins Symptom Checklist, HSCL (25-item version) originally developed by Derogatis and his co-workers (Derogatis *et al.*, 1974). The scale measures psychological symptoms of anxiety, depression and somatisation and was used as a measurement for psychiatric distress in the present study. The items in this scale are scored on a 4-point scale ranging from not at all, a little bit, quite a bit and very much. The scale had a very high internal stability in the present study with a Cronbach's alpha of 0.96. A convention is to use 1.75 as the cut point threshold of 'cases', indicating severe psychological distress (Winokur *et al.*, 1984).

Positive and negative affect was investigated by the use of the Positive and Negative Affectivity Scale (PANAS), which consist of respectively 10+10 items to measure the two affect concepts (Watson *et al.*, 1988). Both of the two affectivity scales had a Cronbach's alpha of 0.90. The respondents were asked about their reactions for the last couple of weeks. Hence, the inventory measured a state condition of positive and negative affectivity.

Comparison groups

The level of post-traumatic stress and psychiatric symptoms among victims of bullying was compared with several other contrast samples, by the means of IES and HSCL. The contrast samples were:

- a. A contrast group of medical students, exposed to a high level of temporary stress (their first autopsy); 96 students (58% female) participated (Eid *et al.*, 1999). Eid and his associates conducted their study to establish a Norwegian control group which can be contrasted against other groups. They argue that their sample is stressed, but not traumatised.
- b. Postal employees ($n=144$, 88% female), all affected by a organisational downsising process (Myrvang & Stokke, 1997).
- c. Recently divorced persons living in five different counties in Norway received a six pages questionnaire along with their official divorce decree during a period of 4 months. In total, 658 separated persons (58% female) participated (Thuen, 2000).
- d. A population study, in which 2,015 individuals were personally interviewed (53% female) from a borough in Oslo and the islands of Lofoten in northern Norway (Sandanger *et al.*, 1998). Out of these, 797 (40%) were classified as 'possible psychiatric cases', after a HSCL-25 recommendation of 1.55+ (Richels *et al.*, 1976). Of these, 617 participated in a follow-up study. Thus, the follow-up study comprise the comparison group for the present study.
- e. Thirty-six parents (50% female) of children in a major bus disaster, in which 12 school children and three accompanying parents died (Winje, 1996). The post-traumatic stress responses of these parents 1 year after the accident will be compared with the victims of bullying.
- f. War zone personnel ($n=213$, United Nation observers/medical helpers), all from Norway, interviewed about 1 year after their service in the Bosnia conflict (Andersen & Tysland, 1998).

The bullied victims were compared to group (a) on PTSS-10, groups (b)–(d) on HSCL-25, and to groups (e)–(f) by the use of IES-R.

Statistics

The statistical analyses were conducted by the use of SPSS, version 8. The following statistical procedures were used: frequency, one way ANOVA, correlation and partial correlation analysis, and multiple linear regression.

Results

Mean PTSS item stress scores of the bullied victims is compared with the comparison group of medical students (Fig. 1, part A). The bullied victims score markedly higher on all items ($p < 0.001$ for all t -test comparisons). It is also worthwhile to note that post-traumatic symptoms with the highest scores are depressive thoughts, isolation tendencies, fluctuating feelings, fear for reminding situations and general bodily tension.

Level of psychiatric distress in the bullied sample, as measured by the HSCL-25, was then compared with postal employees experiencing organisational transition, a sample of separated/divorced persons, and a group of possible psychiatric cases (Myrvang & Stokke, 1997; Raphael *et al.*, 1989; Sandanger *et al.*, 1998). Bullied victims reported higher levels of psychiatric distress than the three contrast groups (part B of Fig. 1). The bullied group reported a mean HSCL-25 level of 2.25, whereas the mean scores for the other three groups were 1.51, 1.43 and 1.30, correspondingly. Parts C and D of Fig. 1 comprises mean post-traumatic stress scores for Impact of Event Scale (intrusion and avoidance sub-indexes). The victims of bullying were compared with the parents of school children involved in a bus

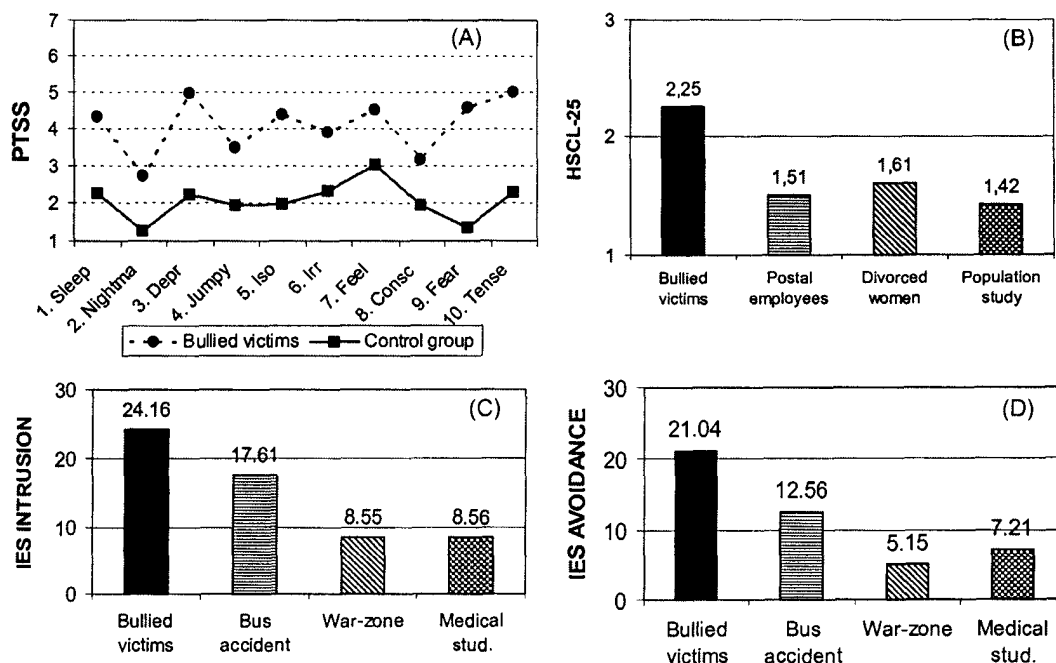


FIG. 1. PTSD symptoms (PTSS-10, IES intrusion IES avoidance) and psychiatric symptoms (HSCL-25) among bullied victims, as compared with several other Norwegian samples.

accident, United Nation personnel 1 year after returning from war zone, and the group of medical students (Andersen & Tysland, 1998; Eid *et al.*, 1999; Winje, 1996). Bullied victims report a mean intrusion and avoidance level of 24.16 and 21.05, respectively. The post-traumatic stress scores among victims of bullying were higher than for all the other three groups.

Table 1 constitutes an estimate of how many of the bullied victims who are troubled with psychiatric distress and PTSD, according to critical cut point scores. The overall picture given by HSCL-25, PTSS-10 and IES-R is quite the same. A majority of the sample, between 60% and 77%, score above the cut point threshold, indicating severe psychiatric distress and PTSD (scores of distress indicating PTSD). Using IES as an overall measure (the three subscales added together) revealed that 72% of the respondents exceeded the recommended cut point threshold.

The second aim of this article was to investigate the association between characteristics of the bullying experience, and the level of reported psychiatric distress and PTSD (Table 2).

Weak interrelationships were found between the subjective feeling of being victimised, number of reported bullies, if one were bullied by a leader or not, the length of the bullying episode and the chosen post-traumatic stress indicators (r = varies between 0.19 and 0.05, p = ns for all of the correlations). However, the amount and kind of specific behaviours experienced in connection with bullying (summed up to an index) showed stronger interrelationship with psychiatric distress and PTSD. Victims reporting the highest exposure to specific negative acts during the bullying episode reported more post-traumatic stress and psychiatric distress than respondents exposed to fewer negative acts (all r s are significant, and varied between 0.28 and 0.41). Victims with the longest time interval since the bullying occurred were troubled the least (r = -0.24 , p < 0.05).

Exposure to negative acts was more thoroughly investigated, correlating each of the 22 specific negative acts with psychiatric distress and PTSD (Table 3). Seven of the negative acts correlated significantly with the stress indices. Ridiculing, hostile or dismissive attitude, ignoring, downgrading or declaring the person incapable due to age or gender, exploitation and sanctions due to working style (working too much or

TABLE 1. Estimated PTSD and psychological distress among bullied victims; conventional cut point scores for IES-R, PTSS-10 and HSCL-25

Scales		<i>n</i>	%
HSCL-25	Low	23	23.5
	High	75	76.5
PTSS-10	Not PTSD	26	25.5
	PTSD	76	74.5
IES intrusion	Low	12	12.0
	Moderate	25	25.0
	High	63	63.0
IES avoidance	Low	14	14.0
	Moderate	26	26.0
	High	60	60.0

TABLE 2. The relationship between bullying, post-traumatic stress and mental distress (Pearson's *r* correlations)

	PTSS-10	IES intrusion	IES avoidance	IES hyperarousal	HSCL-25
Feeling of being bullied ^a	0.15	0.19	0.12	0.16	0.12
Negative acts ^b	0.39***	0.41***	0.36**	0.35**	0.28*
Number who bullied	0.20	0.14	0.15	0.19	0.08
Bullied by leader(s) ^c	0.15	0.06	0.05	0.09	0.09
Length of bullying	0.08	0.09	0.16	0.09	0.05
Time period since bullying	-0.21	-0.24*	-0.14	-0.29*	-0.21

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

1) Feeling of being bullied is a dummy-variable, and comprises two levels: bullied to a certain extent, and strongly bullied.

2) Negative acts consists of 22 negative acts, summed to an index.

3) Dicotimised variable (bullied exclusively by leader(s) vs. bullied by others).

to little) were the only negative acts that were significantly linked to the psychiatric distress and PTSD (*rs* varied between 0.21 and 0.37). Downgrading or declaring the person incapable due to gender had the most consistent relation with the measures of psychiatric distress and PTSD ($p < 0.01$ for all of the correlations).

Time passing by

The possible effect of the passing of time is an interesting one in relation to PTSD. Only one in five (22%) of the sample reported to be bullied at present. This group was compared with victims exposed to bullying more than 1 year ago (66%). The group in between (bullied less than 1 year ago but not being bullied at present) was excluded from this analysis.

Those bullied at present reported a higher level of IES intrusion and IES hyperarousal than those bullied more than 1 year ago ($p < 0.05$ for the two *t*-tests). No significant differences were found in PTSS-10, HSCL-25 or IES avoidance (Table 4). An interesting point is that the mean levels of psychiatric distress and PTSD pass the critical cut point score for both the dichotomised groups of bullied victims (HSCL-25, IES intrusion, IES avoidance). Multivariate analyses were also conducted, to achieve an overall picture of the association between PTSD symptoms and the time variable (consisting of six categories, not dichotomised). The three IES measures were added as dependent variables. The overall association was not found to be significant ($p > 0.05$).

The final issue addressed in this study is whether positive and negative affectivity (state PA and state NA) may moderate or mediate the association between bullying and psychiatric distress/PTSD. The possible moderating effects of state PA and state NA were investigated by the use of multiple regression, whereas the mediator effects were examined by partial correlation analysis. Table 5 gives an overview of a series of regression models, in which psychiatric distress and PTSD were applied as

dependent variables. Time since bullying and negative acts is stepwise entered into various regression models as predictors, followed by PA and NA.

Time since bullying occurred and the specific negative acts explain between 8% and 12% of the variance in the criteria variables. Positive and especially negative affectivity gives substantial contribution to the regression models (all beta values for NA were in the range 0.34 to 0.57, the amount of explained variance increased between 13 and 53%, when PA and NA was added to the models). Reversed multiple regression models were also conducted, that is, with positive and negative affectivity entered into the models as step 1 and the two bullying variables as step 2. Controlled for the positive and negative affect, the variable combination amount of bullying and time since bullying took place gave a significant increase in the regression models predicting post-traumatic stress symptoms: IES ($p < 0.05$, R^2 change, all three subscales) and PTSS. Bullying did not, however, predict psychiatric distress measured by HSCL-25. At most, the two bullying predictors added 9% increase to the models (IES avoidance). All five regression models were tested for an interaction between PA and NA and the two measures on bullying (all combinations). Only one interaction turned out to give a significant contribution to explain variance. The interaction effect between PA and time since bullying occurred gave a 2% increase in the explained variance of psychiatric distress.

Zero-order and second-order partial correlation analysis (pr), respectively, were conducted to examine possible mediator effects of PA or NA related to the link between bullying and traumatic stress reactions. The partial control thus consists of the PA and NA variables in the second-order partial analysis. A considerable difference between the two correlation coefficients may be interpreted as mediator effects of PA and NA. The difference between zero-order and second-order correlations were found to be modest, however: PTSS ($r = 0.27$, $pr = 0.23$), IES avoidance ($r = 0.31$, $pr = 0.28$), IES intrusion ($r = 0.24$, $pr = 0.19$), IES hyperarousal ($r = 0.26$, $pr = 0.22$) and HSCL-25 ($r = 0.20$, $pr = 0.14$). Thus, in sum our study does

TABLE 3. The relationship between various negative acts, psychological functioning and post-traumatic stress; zero-order correlations (Pearson's r)

	PTSS-10	IES intrusion	IES avoidance	IES hyperarousal	HSCL-25
Ridiculing	0.33**	0.12	0.09	0.15	0.31**
Hostile/dismissive attitude	0.21*	0.23*	0.20	0.28**	0.07
Ignoring	0.15	0.20	0.11	0.24*	0.10
Downgrading due to age	0.20	0.20	0.10	0.08	0.23*
Downgrading due to gender	0.32**	0.33***	0.37***	0.27**	0.37**
Exploiting	0.26**	0.22*	0.21*	0.21*	0.36**
Negative reactions because of working too much/too little	0.28**	0.21*	0.05	0.18	0.22*

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$; n varies between 90 and 100.

TABLE 4. Post-traumatic stress and psychological distress; comparison of victims bullied at present vs. victims bullied one year ago or later (Student's *t* tests)

	Bullied now		Bullied before		<i>t</i>	df	<i>p</i>
	M	SD	M	SD			
HSCL-25	2.45	0.49	2.15	0.69	1.79	1/83	ns
PTSS-10	45.81	14.74	39.00	16.27	1.74	1/86	ns
IES intrusion	27.04	6.44	20.76	10.90	2.55	1/85	<0.05
IES avoidance	22.61	9.24	19.52	10.12	1.24	1/85	ns
IES hyperarousal	25.07	7.72	18.97	11.01	2.35	1/85	<0.05

TABLE 5. Multiple regression models with time since bullying occurred, negative acts, positive affectivity (PA) and negative affective (NA) as predictors, and with measures of psychological distress and post-traumatic stress as criteria variables; strongest (if significant) interactional term is included in each model

	beta	<i>R</i> ²	<i>R</i> ² Change	<i>F</i> Change
PTSS-10				
Time	-0.23	0.05	0.05	5.73*
Amount of bullying	0.29	0.12	0.07	9.61**
PA	-0.43	0.30	0.18	26.06***
NA	0.50	0.49	0.19	37.66***
IES intrusion				
Time	-0.17	0.02	0.02	2.96
Amount of bullying	0.33	0.12	0.10	12.31***
PA	-0.20	0.16	0.04	4.58*
NA	0.35	0.24	0.08	11.74***
IES avoidance				
Time	-0.38	0.06	0.06	7.72**
Amount of bullying	0.11	0.11	0.05	6.13*
PA	-0.11	0.21	0.10	13.96***
NA	0.34	0.43	0.22	37.66***
IES hyperarousal				
Time	-0.25	0.05	0.05	6.87**
Amount of bullying	0.28	0.12	0.07	8.92**
PA	-0.34	0.24	0.10	15.09***
NA	0.57	0.48	0.24	46.63***
HSCL-25				
Time	-0.24	0.05	0.05	6.09*
Amount of bullying	-0.20	0.09	0.04	4.37*
PA	-0.57	0.36	0.27	44.24***
NA	0.57	0.61	0.25	62.44***
PA × time	-0.44	0.64	0.03	6.69*

p* < 0.05, *p* < 0.01, ****p* < 0.001.

not confirm moderating or mediating effect of state PA and state NA regarding the bullying–traumatic stress connection.

Discussion

Information about the prevalence of PTSD among victims of bullying may be useful in order to inform health care professionals as well as the legal system of the possible extreme consequences of such experiences. The description of specific symptoms may also benefit victims directly by informing them of symptoms experienced by others. In itself this may reduce any anxiety and fear of ‘going crazy’ (Saunders, 1994). Practitioners also need to be informed of the symptoms displayed by victims of bullying, thus preventing the misdiagnosis that often seems to occur when victims seek medical or psychological treatment (Einarsen, 2000; Leymann & Gustavson, 1996). Many victims may be incorrectly diagnosed by professionals receiving diagnoses such as paranoia, manic depression, or character disturbance (Leymann & Gustavson, 1996) which may give rise to further stigmatisation. The frequency and intensity of post-trauma symptoms diminish gradually over time, although the symptoms may never completely disappear (Foa & Riggs, 1995). This decline was demonstrated in two research studies examining changes in the prevalence of PTSD following assault (Foa & Riggs, 1995; Rothbaum *et al.*, 1992). In both studies female victims of rape and non-sexual assault were assessed repeatedly over a period of 3 months, with the onset of assessment starting about 14 days after the traumatic event. It was found that 94% of rape victims and 76% of non-sexual assault victims met symptom criteria for PTSD at the initial assessment, diminishing to, respectively, 47% and 22% after 11 weeks.

Several studies have demonstrated that bullying at work poses a serious threat to the health and well-being of those at the receiving end (Einarsen *et al.*, 1996; Zapf *et al.*, 1996). Delayed injuries of bullying, in which the victim perhaps has retired from active work, has been investigated to a very limited extent so far. The notion that victims of bullying are exposed to such health hazards causing Post-Traumatic Stress Disorder has, with a few exceptions (see e.g. Leymann & Gustavson, 1996; Mikkelsen & Einarsen, 2002a), not been investigated. The present study indicates that psychiatric distress and PTSD may be widespread among victims of bullying at work. Some three out of four respondents scored above the recommended IES and PTSS threshold for PTSD. Comparison with a host of other samples, like separated or divorced people, war zone personnel, postal employees after an organisational downsize, and a sample of possible psychiatric cases, indicates that our sample of bullied victims portrays an especially high level of stress. The findings should not be interpreted as indicating that exposure to bullying is worse than the aftermath of losing your kids in a bus accident, or being traumatised in a war zone.

According to Janoff-Bulman (1992), post-traumatic stress following victimisation is largely due to the shattering of basic assumptions victims hold about themselves and the world, in which the feeling of personal invulnerability constitutes an important part. The sense of invulnerability is tied to the three core beliefs: (a) the

world as benevolent, (b) the world as meaningful, and (c) the self as worthy. Also, the just world hypothesis (Lerner, 1980), that is, our need to believe that we live in a world where people get what they deserve and deserve what they get, seems to be shattered by the experience of being bullied. The belief in a just world and the three core beliefs enables the individual to confront the physical and social environment as if it were stable, orderly, coherent, safe and friendly. A traumatic event presents information that is incompatible with these existing mental models, or schemas (Horowitz, 1975, 1979).

This incongruity gives rise to stress responses requiring reappraisal and revision of the schemas. The person tends to use avoidance strategies in order to ward off distressing thoughts, images and feelings caused by the incident, thus giving the control system tolerable doses of information. Phases of intrusion and avoidance occur as the person attempts to process or 'work through' the experience (Horowitz, 1975). The bullied victim may repeatedly re-experience the most humiliating or frustrating aggressive events for his/her 'inner eye', or the person may systematically avoid certain work situations, be it lunch breaks, meetings or other people while at work. They may even experience it as difficult to approach or pass a former workplace, as described in one particular case study (Einarsen & Hellesøy, 1998). A traumatised and stigmatised person may, due to excessive bullying at work, have a strong shattered experience of the world as not being a just, meaningful and benevolent place, with a strong anticipation of future misfortune to come. These experiences can be induced later on, for instance, after the person has ended his/her job or even the job career. Following may be a state of extreme anxiety and hyperarousal, in the long run causing a breakdown of basic psycho-biological systems.

It is tempting to assume that the bullied victims are particularly hit by the shattering of the world as not being a benevolent place, and poor self-esteem after the devastating incidents. Another important assumption is the just world hypothesis (Lerner, 1980). People have a need to believe that they live in a world where people get what they deserve and deserve what they get. The belief in a just world enables the individual to confront the physical and social environment as if it were stable and orderly. A traumatised person experiencing bullying at work may have a strong shattered experience of the world as not being a just place, with a strong anticipation of future misfortune to come (Mikkelsen & Einarsen, 2002a). Traditionally, PTSD is regarded as a postponed negative health effect after the exposure to one shocking, stultifying stressor, e.g. an accident. The traumatic event can usually not be predicted, with natural disasters, mechanical failures or human errors typically being the triggering factors.

Bullying, at work or at school, is a somewhat different phenomenon, since it is a cumulative trauma (type 2 trauma). Jarring personal chemistry, escalating conflict episodes and dismissive interpersonal behaviour may gradually turn into mortifying bullying (Einarsen, 1999). The disaster is socially created, and at least on the psychologically level the victim feels that s/he cannot escape from this devastating traumatic situation. Other studies have demonstrated that being forced to stay in a life situation filled with traumatic episodes for a long time may result in PTSD, e.g.

study findings from concentration camp survivors (Eitinger & Strøm, 1973). Learned helplessness (Seligman, 1975), a sense of being unable to cope with destiny, may be a reaction bullied victims and concentration camp prisoners have in common, with PTSD as a negative health after effect.

Respondents who reported exposure to many different kinds of specific negative acts are troubled the most with post-traumatic stress. A somewhat surprising finding was the modest relationship between 'being bullied by leaders' and post-traumatic stress. Other studies have found that individuals to a great extent are struck by health complaints when bullied by their superiors (Björkqvist *et al.*, 1994). Leaders are influential and possess more power than colleagues, which means that they can exert sanctions against the victim as part of a conflict process. Bullying by superiors seems to be widespread among the participants of this study. It is possible that modest interrelationships between leadership harassment and post-traumatic stress was due to a relatively homogenous sample. Length of bullying was not associated with post-traumatic stress, which could be explained with a homogeneous sample, with low between subject variance.

Victimisation from bullying comprises a subjective experience. All types of situations can in principle be experienced as conflict episodes, according to Thomas' (1976) conflict definition. Most kinds of behaviours perceived as negative and directed at a person with a perceived aim to be hurtful may also lead to a perception of being bullied, at least if they are exhibited over a prolonged period of time (Einarsen *et al.*, 2003). Irrespective of this is it of crucial importance to gather information about negative acts that causes perceptions of being bullied, and PTSD in the next round. In his work Leymann (1990b) lists 47 negative acts potentially to perceived as precursors of bullying, whereas this survey maps 22 negative acts (the measure of NAQ), chosen from clinical and empirical experience. It is possible, however, that certain kinds of negative acts are experienced as more stressful than others. In the present study downgrading or incapacitating due to gender correlates quite strongly with post-traumatic stress. An adjacent finding is the revealed link between working style and traumatic stress. Downgrading due to gender and bullying because of working style could be seen as different expressions of tension between male and female employees at work.

Post-traumatic stress implies that the health weakening symptoms persist, or emerge with new intensity long after the actual trauma has ceased. Although this survey revealed that symptoms weakened somewhat as time goes by, the effect of time relationship was moderate. The small differences between victims exposed to present bullying and victims in which the bullying ceased more than a year ago support a notion that time only to a limited extent heals all wounds. The relationship between bullying and positive and negative affectivity has been demonstrated in previous research (Mikkelsen & Einarsen, 2002a). Negative affectivity has been seen as an important source of 'emotional dissonance' in organisations, and is linked to role conflict (Abraham, 1998). It has been found, furthermore, that negative affectivity also co-varies with interpersonal conflicts (Spector & O'Connell, 1994). Positive affectivity corresponds with, for example, organisational commitment (Cropanzano *et al.*, 1993) and prosocial behaviour (Lawton *et al.*, 1997). It has

been argued that negative affectivity should be applied as a control variable within stress research, because NA could reveal spurious relationship between strain and stress reactions, as stated by Watson and Clark (1984) in their seminal work. An example of such interrelationships could be the perception of exposure to negative acts at work, as seen in bullying. In this study it was unveiled that weak (non-significant) interaction effects between all combinations of PA, NA and the most important bullying predictors related to post-traumatic stress. The mediator effects of PA and NA were also modest. These findings stultify the notion that NA modifies most interconnections between strain and reaction measures, and is in line with Mikkelsen and Einarsen (2002b).

Still, NA seems to have a stronger direct effect on the PTSD-indicators than does PA. These findings support previous research, where NA co-varies the most with stress and health indicators, and PA with satisfaction and well-being indicators (Watson, 1988). Also found is a stronger interrelationship between post-traumatic avoidance and hyperarousal reactions, compared with post-traumatic intrusional thoughts and flashbacks. This could indicate that it is particularly bullied victims characterised by an evasive behaviour, and strong stress arousal, who are struck by PTSD problems.

Conclusion

Using established tests of PTSD, a very high level of post-traumatic stress symptoms was revealed in the present study. This finding corresponds with previous research (Leymann & Gustavson, 1996; Mikkelsen & Einarsen, 2002a). A majority of the respondents exceed recommended threshold-values indicating PTSD. It is important to underline that our findings are only indicators of PTSD problems among the victims, since we did not undertake diagnostic interviews with the respondents. It remains a debatable question whether PTSD is an appropriate psychiatric diagnosis in the case of bullying at work, at least according to the criteria of DSM-IV. In our opinion, one should evaluate this aspect in an open-minded manner, since the PTSD diagnosis and DSM have undergone several revisions over the course of time.

Other methodological constraints must also be considered in the interpretation of the present findings. The participants comprise a selected group: they have all been recruited from two associations of bullied victims. The sample could consist of more injured people than what is typical for victims of bullying. It is reasonable, on the other hand, to assume that many individuals exposed to bullying at work do not have sufficient go-ahead spirit or strength to seek allies, e.g. by forming or contacting a bullying association. Many bullied victims express feelings of emotional constriction after being a victim of bullying. They refuse to confide in someone what they experience at work, male victims in particular (Einarsen *et al.*, 1994). The present sample consists on average of quite educated people, most women, working in white collar professions. However, an other study revealed that blue collar workers are more exposed to bullying than others (Einarsen & Skogstad, 1996). Hence, the participants of this study may not comprise a representative sample. Social

desirability (Crowne & Marlowe, 1964) represents another issue to be taken into consideration. Sceptics may claim that it is reasonable to assume that the participants in the present study, being members of bullied victims associations, consciously or unconsciously will express their feelings in a particularly negative light, in order to finally gain the attention their problems deserve.

As illuminated by this article, PTSD related to bullying at work constitutes a research field with scarce research attention so far. The field deserves follow-up studies. Longitudinal research should be conducted in particular, since the time factor is essential for our understanding of the progress of PTSD. A suggestion for follow-up studies, also, is that diagnostic interviews are implemented as part of the research design, as, for instance, performed by Dyregrov and associates in their studies among war children (Dyregrov *et al.*, 2000, 2002).

Irrespective of PTSD, the topic of bullying at work lacks longitudinal research designs, which should be applied during the forthcoming years. Particularly, personality issues should be investigated. Some victims of bullying may be more vulnerable than others, as indicated in a previous study (Matthiesen & Einarsen, 2001). Correspondingly, the strong direct link found between negative affectivity and PTSD symptoms in this study may indicate that there is a strong personality component in the phenomenology of bullying.

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356 *Stig Berge Matthiesen & Ståle Einarsen*

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EXHIBIT

A26

Workplace bullying and its relation with work characteristics, personality, and post-traumatic stress symptoms: an integrated model

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Workplace bullying refers to prolonged exposure to frequent hostile behaviors at work, which can lead to severe stress reactions. Research in this area has not revealed a clear picture on how bullying escalates in organizations. Drawing on recent developments in work stress theory, this study tested a comprehensive model of bullying in which work environmental and personality factors were hypothesized to act as antecedents of bullying and post-traumatic stress symptoms as an outcome. Structural equation modeling on data provided by 609 public sector employees in Italy showed that job demands (workload and role conflict) and job resources (decision authority, co-worker support and salary/promotion prospects) were related to bullying over and above neuroticism, and that bullying mediated the relationship between job demands and PTSD symptoms. Evidence also emerged for a buffering effect of job resources on the job demands–bullying relationship. Overall results are compatible with a view of bullying as a strain phenomenon, initiated by both work environmental and personality factors.

Keywords: workplace bullying; victimization; PTSD symptoms; job demands-resources model; bullying model; neuroticism

The phenomenon of workplace bullying, first described by Leymann (e.g., 1996), refers to prolonged exposure to frequent hostile behaviors at work, such as excessive criticism of one's work, withholding of information which affects performance, spreading of rumours, social isolation, etc. (Einarsen, Hoel, Zapf, & Cooper, 2010). In the long run these behaviors may lead to the stigmatisation and victimization of the exposed individual (Einarsen & Mikkelsen, 2003).

Despite important advancements in terms of refinement of the construct and understanding of the individual effects of the phenomenon, workplace bullying is still a topic in which there is a need for further research (Bowling & Beehr, 2006). This is because research on the antecedents of bullying and on the effect of possible preventive interventions is still in its infancy. Thus, in the present study we contribute to research in this area by developing and testing an overall model of bullying which presents the following three unique features: it integrates work environmental and

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personality factors as potential preconditions of bullying; it includes not only traditional job stressors but also buffering resources; and it examines post-traumatic stress disorder (PTSD; American Psychiatric Association [APA], 2000) symptomatology as a possible consequence of the bullying-related victimization.

Development of bullying: the role of work environmental and personality factors

Most research on the development of bullying has examined either the role of the work environment (see Salin & Hoel, 2010) or the role of the characteristics of the victim (see Zapf & Einarsen, 2010). According to the work environment hypothesis (e.g., Leymann, 1996), poor psychosocial conditions at work (e.g. role ambiguity and role conflict) may trigger interpersonal conflicts, which if not properly managed may escalate into bullying.

However, empirical data on the work environment hypothesis are not conclusive. While research has shown (e.g., Leymann, 1996; Vartia, 1996) that victims of bullying report poor psychosocial work environments (a more competitive social climate, higher workload, less social support, etc.), the systematic investigation of predicting factors and explaining processes of workplace bullying in the light of more robust models of work stress has only recently started up. Agervold and Mikkelsen (2004), in one of the first studies, found that employees who were frequently exposed to bullying reported less job control, work tasks which were more unclear or contradictory, a management style which was less employee-oriented, and fewer social contacts with co-workers. More recently, Skogstad, Einarsen, Torsheim, Aasland and Hetland (2007) found that a *laissez faire* leadership style as well as role conflict and role ambiguity were antecedents of bullying, with role stressors mediating the effect of abdicating leadership on bullying. These findings were corroborated by Hauge, Skogstad, and Einarsen (2007), who found that leadership variables were substantially related to bullying over and above other job stress-inducing factors such as role stressors, job demands and decision authority. In a meta-analysis, Bowling and Beehr (2006) reported that work constraints, role conflict and role ambiguity are the strongest potential antecedents of workplace harassment. In line with these results, on the basis of the analysis of 148 organizational ethnographies, Hodson, Roscigno, and Lopez (2006) concluded that coherent production procedures provide a context in which bullying is unnecessary and disallowed.

However, all of the studies reviewed above on the work environment hypothesis of bullying neglect the role of personality factors. This is an important shortcoming, since there is strong evidence for a relationship between bullying and certain personality traits (Zapf & Einarsen; 2010). Coyne, Smith-Lee Chong, Seigne, and Randll (2003), for example, found that victims of bullying displayed a tendency, in comparison to controls, to be easily upset and were more likely to experience difficulty in coping with personal criticism; they also tended to be more anxious, tense, and suspicious of others. Similar results were reported in a sample of victims who sought clinical advice (Brousse et al., 2008). In this study 88% of the victims reported high trait neuroticism at first consultation, with this percentage remaining statistically unchanged at the one-year follow-up. In a Finnish study of hospital employees, Kivimäki et al. (2003) showed not only that undergoing bullying predicted the incidence of depression, but also that the presence of a diagnosis of

depression predicted the incidence of bullying, suggesting that personal psychological factors may be implicated in bullying. Finally, Bowling, Beehr, Bennett and Watson (2010) recently found a significant longitudinal relationship between negative affectivity – which includes a general proneness to experience anger, fear, sadness, and other negative feelings (Watson & Pennebaker, 1989) – and workplace victimization.

A comprehensive model of bullying

Research on work environmental and personality factors as antecedents of bullying has mostly been parallel in nature. Thus, in the present study we test a model of the experience of bullying and its consequences in which we integrate both types of factors.

To operationalize the effect of the work environment on bullying, we use the framework of a recently introduced model of work stress: the job demands-resources (JD-R) model (e.g. Bakker & Demerouti, 2007). According to the JD-R model, the psychosocial characteristics of the work environment may be differentiated into two overarching factors: job demands and job resources. Job demands refer to aspects of the job (e.g. physical and psychological demands) that require physical or mental effort and that therefore may generate work-related stress, thus acting as a potential triggering factor for interpersonal conflicts and bullying. Job resources, on the other hand, are those aspects (e.g. decision latitude and social support) that are functional in reaching work goals and/or in reducing job demands and that may protect individual health and promote well-being. Therefore, job resources may be hypothesized as acting as a buffering factor in the escalation of bullying, which would be consistent with the widely known buffering hypothesis.

As far as personality is concerned, we focus on neuroticism, which has been found to be a potentially important factor in bullying (e.g. Coyne et al., 2003). However, of particular interest to unravel the process of bullying escalation is to look at whether neuroticism strengthens the job demands–bullying relationship. This would be in line with the idea of a differential reactivity to environmental stressors of people with high neuroticism (Warr, 2007), which could increase their risk of becoming victims of bullying. Different mechanisms may explain the strengthening effect of neuroticism on the job demands–bullying relationship (Bowling et al., 2010). For example, under distressing working conditions highly neurotic employees may engage more often in annoying behaviors, which could lead potential perpetrators to bully them.

A final aspect of novelty of the proposed model of bullying is that PTSD symptoms are examined as a possible consequence of the phenomenon. Although it is a matter of debate whether bullying has all the characteristics of an overwhelming traumatic event (Mikkelsen & Einarsen, 2002), which is a prerequisite condition for the diagnosis of PTSD, a number of studies indeed found a relationship between bullying and PTSD symptoms (e.g., Balducci, Alfano, & Fraccaroli, 2009; Mikkelsen & Einarsen, 2002). However, a potential limitation of these studies is that in none of the cases was an organizational sample of participants included. Rather, contacts were made either with victims from anti-bullying associations (Mikkelsen & Einarsen, 2002) or with victims who sought clinical consultation (Balducci et al., 2009). These victims may differ from bullying victims in general (Nielsen & Einarsen,

2008). For example, they may represent only the most extreme cases of bullying, ending with expulsion of the victim from the labour market (Leymann, 1996), which may be the real factor leading to PTSD symptoms. If bullying has indeed traumatic potential, then the relationship between bullying and PTSD symptoms should also emerge in organizational samples, which has never been investigated in previous research. Furthermore, since there is evidence for a relationship between work environmental factors and bullying (Hauge et al., 2007) and between bullying and PTSD symptoms (Balducci et al., 2009), then the hypothesis may also be investigated that bullying acts as a mediator in the relationship between work environmental factors and PTSD symptoms.

On the basis of the above considerations, we thus tested the following hypotheses:

Hypothesis 1: Work environmental factors and neuroticism would be related to the experience of bullying. Specifically, job demands and neuroticism would show a positive relationship with bullying, while job resources a negative relationship with bullying.

Hypothesis 2: Bullying would be positively related to PTSD symptoms.

Hypothesis 3: Job resources would moderate the job demands–bullying relationship.

Hypothesis 4: Neuroticism would strengthen the job demands–bullying relationship.

Hypothesis 5: Bullying would mediate the job demands–PTSD symptoms relationship.

Method

Participants

Data were collected as part of a psychosocial risk assessment conducted in 2007 in a large public administration agency in Italy. Employees in non-managerial positions, most of whom carrying out administrative work, were requested to fill in a structured, anonymous questionnaire investigating a number of psychosocial aspects of work and health outcomes. The questionnaire was administered during working hours; participation was on a voluntary basis. A total of 818 employees participated. The study sample consisted of the 609 participants who had complete data on all study variables. Response rate of the study sample was 43.78%. Gender was female in 49.4% of the cases, which represented fairly well the gender distribution of the organization (49.2% were females). Age of participants was distributed as follows: .5% were 20–29 years, 23.9% were 30–39, 43.0% were 40–49, 28.8% were 50–59 and 3.8% were 60 or more. As for the age distribution in the population, 65% of employees were aged 40 years or above, which indicates that the sample had a certain approximation to the population as far as age is concerned. Most participants (98.3%) had a permanent job contract. Given the sensitive nature of the questionnaire contents, no further demographic or occupational data were collected.

Instruments

Workplace bullying was investigated by using a 9-item version (Notelaers & Einarsen, 2008) of the Negative Acts Questionnaire-Revised (NAQ-R; Einarsen, Hoel, & Notelaers, 2009). The NAQ-R explores how often the respondent has been subjected to a number of negative behaviors at work in the last six months, such as

“Someone withholding information which affects performance.” Responses varies from 0 (“Never”) to 4 (“Daily”). We obtained a Cronbach’s alpha of .82 for the adopted version of the scale. The items of the short NAQ-R explores three 3-item components of bullying (i.e., work-related bullying, person-related bullying and social isolation), which were taken as the observed indicators of the underlying construct. Cronbach’s alpha of observed variables used in the analyses is reported in Table 1.

Symptoms of PTSD were explored by using a validated brief version of the PTSD Checklist-civilian scale (PCL-C; Lang & Stein, 2005). This version includes six items forming three 2-item subscales (i.e., re-experiencing, avoidance, and hyper-arousal) which investigate the three types of symptoms of PTSD as defined by the DSM IV-TR (APA, 2000). An example item is “Experienced repeated, disturbing memories, thoughts or images of the traumatic event.” Responses to items were in terms of symptoms intensity and varied from 1 (“Not at all”) to 5 (“Extremely”). Where the original item was anchored to “the traumatic event,” we modified the item by anchoring it to “the negative behaviors” defining bullying. The overall alpha for the scale was .89. In the analyses we used the three 2-item measures defined above as observed indicators of the investigated construct.

As for job demands, previous qualitative interviews conducted by the first author with employees suggested that two common sources of stress were role stressors and work overload. We therefore operationalized job demands in terms of role conflict and workload. Role conflict was measured by using six items (e.g., “I receive incompatible requests from two or more people”) from the role conflict scale developed by Rizzo, House, and Lirtzman (1970). Responses ranged from 1 (“Completely true”) to 5 (“Completely false”), with items being reverse coded before computing the scale total. Workload was measured by using the five-item Effort scale from the Effort-Reward Imbalance questionnaire (ERI; Siegrist et al., 2004). An example item is “I have constant time pressure due to a heavy workload.” Responses on this scale vary from 1 (“Disagree”) to 5 (“Agree, and I’m very disturbed by this”).

We operationalized job resources in terms of autonomy, promotion prospects, and co-workers support – factors that emerged as important helping elements in the studied organization. These are job resources with potential importance in most work settings (e.g., Warr, 2007). Autonomy was measured by three items forming the decision authority scale of the Job Content Questionnaire (JCQ; Karasek et al., 1998). An example item is “In the organization of my work I have a lot to say.” Responses vary on a 4-point scale ranging from 1 (“Strongly disagree”) to 4 (“Strongly agree”). Promotion prospects were evaluated by using the Salary/promotion scale from the ERI questionnaire (Siegrist et al., 2004), which is composed of four items such as “Considering all my efforts and achievements, my job promotion prospects are adequate.” Responses were given on a 5-point scale ranging from 1 (“Yes”) to 5 (“No, and I’m very disturbed by this”). Items were recoded, when necessary, so that higher scores meant higher job promotion prospects. Co-workers support was measured by four items from the JCQ (Karasek et al., 1998). Responses were given on a 4-point scale ranging from 1 (“Strongly disagree”) to 4 (“Strongly agree”); an example item is: “My co-workers are friendly with me.”

Table 1. Properties and Pearson's product moment correlations of the study variables ($N=609$).

Variable	<i>M</i>	<i>SD</i>	α	1	2	3	4	5	6	7	8	9	10	11	12	13
1. NAQ-Work-related bullying	0.50	0.6	.66	–												
2. NAQ-Personal bullying	0.47	0.6	.71	.57**	–											
3. NAQ-Social isolation	0.34	0.5	.58	.60**	.59**	–										
4. PTSD-Re-experiencing	1.47	0.8	.87	.47**	.43**	.46**	–									
5. PTSD-Avoidance	1.67	0.9	.76	.38**	.39**	.44**	.71**	–								
6. PTSD-Hyperarousal	1.50	0.8	.79	.42**	.41**	.42**	.64**	.62**	–							
7. Role conflict	2.40	0.8	.76	.37**	.24**	.27**	.23**	.25**	.28**	–						
8. Workload	1.96	0.7	.84	.26**	.27**	.25**	.30**	.23**	.31**	.34**	–					
9. Salary/promotion prospects	3.31	1.1	.81	–.29**	–.19**	–.26**	–.29**	–.29**	–.26**	–.26**	–.20**	–				
10. Coworker support	2.80	0.3	.73	–.26**	–.27**	–.31**	–.16**	–.20**	–.13**	–.15**	–.12**	.27**	–			
11. Decision authority	2.70	0.5	.69	–.21**	–.17**	–.13**	–.22**	–.17**	–.17**	–.15**	.08*	.24**	.13**	–		
12. Neuroticism	2.08	0.8	.90	.30**	.22**	.28**	.39**	.31**	.41**	.21**	.25**	–.08	–.08	–.15**	–	
13. Gender ^a	–	–	–	.15**	.12**	.02	.04	.11**	.03	.10*	.21**	–.03	–.09*	–.11**	.10*	–

Note: ^aCoded as: 0 = male; 1 = females.* $p < .05$. ** $p < .01$.

Neuroticism was measured by using a 9-item scale (e.g., “I get upset easily”) derived from a big-five personality inventory included in the International Personality Item Pool (IPIP; Goldberg, 1999). Responses varied from 1 (“Not at all”) to 5 (“Completely”).

Analyses

Hypotheses were tested by using structural equation modeling (SEM) as implemented by LISREL 8.71. In order to test for the two hypothesized interactions (job demands \times job resources and job demands \times neuroticism) on bullying (see Hypothesis 3 and Hypothesis 4), we used moderated structural equation modeling (MSEM; Cortina, Chen, & Dunlap, 2001). More details on MSEM are given below. To test for the postulated mediation model of bullying (Hypothesis 5), we used the Sobel (1986) test.

The fit of the structural equation models was evaluated by using the χ^2 statistic and a variety of other practical fit indices. Models showing values of up to .08 at the Root Mean Square Error of Approximation (RMSEA) and values of .90 or higher at the Normed Fit Index (NFI), Non-Normed Fit Index (NNFI), Comparative Fit Index (CFI), Goodness of Fit Index (GFI) and its adjusted form (AGFI) are usually considered as acceptable (see Tabachnick & Fidell, 2007). Models showing values of up to .06 at the RMSEA and values of .95 or higher at the NFI, NNFI and CFI are considered as good (Hu & Bentler, 1999).

Results

Preliminary analyses

Since the study sample ($N = 609$) was obtained by using listwise deletion of cases from the initial sample ($N = 818$), we preliminarily checked whether the excluded cases differed from the included ones on the three bullying measures (i.e., the crucial study variables). Three t -tests did not reveal any difference between the two groups: $t(729) = 1.22$, ns , for work-related bullying; $t(727) = 1.13$, ns , for person-related bullying; and $t(738) = .44$, ns , for social isolation.

Properties of study variables and correlations are reported in Table 1. We also included gender in these analyses since gender has been found to be the strongest predictor of PTSD (Nemeroff et al., 2006). However, gender did not show strong correlations with PTSD symptoms in the present study (see Table 1); thus, we finally decided to leave it out from further analysis.

We then tested whether the joint distribution of observed variables was multivariate normal. Results of these tests revealed that this assumption did not hold – for example, the test for multivariate skewness was statistically significant ($Z = 25.88$; $p < .001$). Thus, to improve parameters' estimation, we run all SEM analyses by using the robust maximum likelihood method (Olsson, Foss, Troye, & Howell, 2000).

Finally, before testing our main hypotheses, we checked for whether the latent factors job demands and job resources could be differentiated empirically. To this end we used confirmatory factor analysis (CFA), comparing the fit of a second order two-factor (job demands and job resources) model to the fit of a second order one-factor (psychosocial risk) model. In the two-factor model the first order factors were

role conflict and workload for job demands, while promotion prospects, co-workers support and autonomy for job resources. In the one-factor model the same first order factors all loaded on a second-order psychosocial risk factor. Observed measures for these preliminary analyses were the following: role conflict, workload, promotion prospects and co-worker support were each indicated by two randomly derived parcels, while autonomy by the three component items. CFA results for the one-factor model were the following: χ^2 (39) = 198.66; GFI = .94; AGFI = .91; RMSEA = .077; NFI = .91; NNFI = .90; CFI = .93. Results for the two-factor model were the following: χ^2 (38) = 139.94; GFI = .96; AGFI = .93; RMSEA = .062; NFI = .94; NNFI = .93; CFI = .95. Satorra and Bentler (2001) scaled χ^2 difference test (S-B $\Delta \chi^2$) indicated that the two-factor model fitted significantly better than the one-factor model, S-B $\Delta \chi^2$ (1) = 44.41, $p < .001$. The estimated correlation between the second-order job demands and job resources factors was $\phi = -.41$. On the whole, the data supported the differentiation of a latent job demands factor from a latent job resources factor.

Test of main hypotheses

MSEM was implemented by using the technique outlined by Mathieu, Tannenbaum, and Salas (1992) as reported in Cortina et al. (2001). In this analyses, job demands, job resources, neuroticism and each of the successive interactions tested (job demands \times job resources and job demands \times neuroticism) had only one observed indicator. The indicator for job demands, job resources and neuroticism was obtained by summing and standardizing (i.e., centering) the scores on the variables involved in the definition of the factor. The indicator of the interaction factor was the product of the two scores of the indicators defining the interacting factors. The path from each of the factors to its indicator was fixed by using the square root of the reliability of the indicator. The reliabilities of the job demands, job resources, and neuroticism indicators were estimated by means of their Cronbach's alpha. The reliability of the indicator for the interaction factor was computed by taking the product of the reliabilities of the interacting factors' indicators (e.g., job demands and job resources) plus the square of the latent correlation between the same factors, divided by one plus the square of the same latent correlation just mentioned (Cortina et al., 2001). The error variance of the observed indicator for each factor was set equal to the product of its variance and one minus its reliability. The correlation between each of the two interacting factors and the factor representing their interaction was fixed at zero (Cortina et al., 2001). A significant interaction effect is supported when the path coefficient from the latent interaction factor to the latent target factor is statistically significant and the model including this path fits significantly better, as evaluated by a difference in the χ^2 statistic, than the model which does not include this same path.

Thus, each MSEM analysis included six factors: job demands, job resources, neuroticism, the focused interaction, bullying, and PTSD symptoms, with each of the latter two factors being defined by its three observed indicators (see Method section). The tested models were in line with the proposed hypotheses, such that job demands, job resources, neuroticism and each of the interaction factors tested were all related to bullying, while bullying was related to PTSD symptoms. We also included a direct relationship between neuroticism and PTSD symptoms in the model; this is because

neuroticism has been found to be related to the experience and onset of anxiety symptoms and disorders (Clark, Watson, & Mineka, 1994). Table 2, Models 1–2, reports the results of MSEM testing for Hypotheses 1–3 that work environmental factors (i.e., job demands and job resources) and neuroticism would be related to bullying, that bullying would be related to PTSD symptoms, and that job resources would moderate the job demands–bullying relationship, respectively.

A comparison between Model 1 and Model 2, which differed for the inclusion in Model 2 of a direct path from the interaction factor to the bullying factor, indicated that the difference in their χ^2 value was statistically significant (S-B $\Delta\chi^2_{M1-M2}(1) = 3.96; p < .05$). Model 2 is graphically represented in Figure 1, from where it can be seen that job demands ($\gamma = .30; p < .05$), job resources ($\gamma = -.36; p < .05$), and neuroticism ($\gamma = .22; p < .05$) were all related to bullying in the expected direction and that bullying was strongly positively related to PTSD symptoms ($\gamma = .61; p < .05$). Thus, we found evidence in line with Hypothesis 1 and Hypothesis 2. Furthermore, the interaction (job demands \times job resources) factor showed also a modest but significant negative relationship with bullying ($\gamma = -.13; p < .05$), with simple slope analysis (Figure 2) indicating that at higher levels of job resources the job demands–bullying relationship was weaker. Thus, we also found evidence in line with Hypothesis 3.

Table 2, Models 3–4, reports the results of MSEM testing for Hypotheses 4 that neuroticism would strengthen the job demands–bullying relationship. A comparison between Model 3 and Model 4, which differed for the inclusion in Model 4 of a path from the job demands \times neuroticism interaction factor to the bullying factor, indicated that their fit was not significantly different. Thus we did not find evidence in line with Hypothesis 4.

To look at whether bullying would mediate the relationship between job demands and PTSD symptoms (Hypothesis 5), we focused on Model 2 (see Figure 1) and used

Table 2. Results of SEM analyses.

Model	χ^2	df	GFI	AGFI	RMSEA	NFI	NNFI	CFI
Model 1 (JD \times JR interaction on bullying: main effects only)	58.769**	30	.970	.944	.039 (.023–.054)	.985	.989	.993
Model 2 (JD \times JR interaction on bullying: main and interaction effects)	54.734**	29	.972	.946	.038 (.022–.053)	.987	.990	.994
Model 3 (JD \times neuroticism interaction on bullying: main effects only)	55.837**	30	.971	.946	.038 (.022–.053)	.985	.990	.993
Model 4 (JD \times neuroticism interaction on bullying: main and interaction effects)	55.925**	29	.971	.945	.039 (.023–.054)	.985	.989	.992

Note: JD, job demands; JR, job resources; GFI, goodness of fit index; AGFI, adjusted goodness of fit index; RMSEA, root mean square error of approximation; NFI, normed fit index; NNFI, non-normed fit index; CFI, comparative fit index.

** $p < .01$.

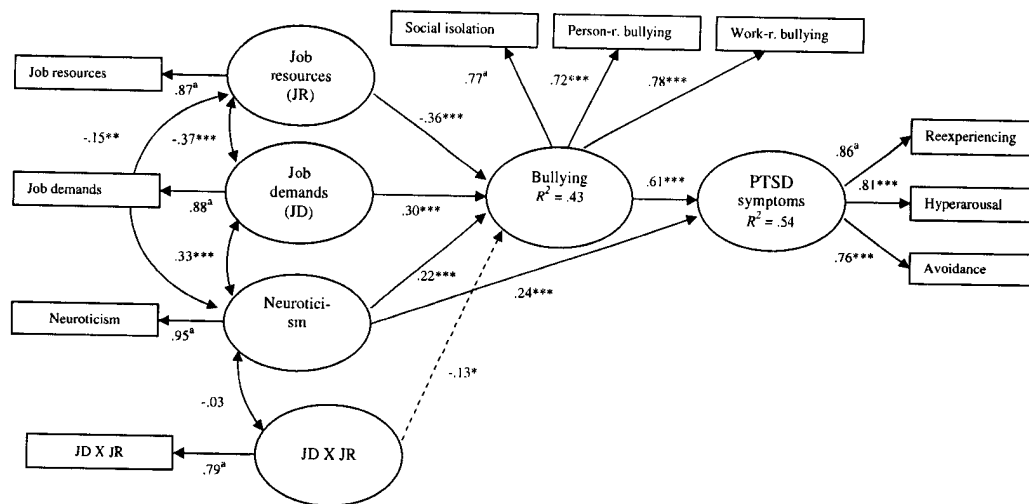


Figure 1. Moderation of job resources on the relationship between job demands and workplace bullying.

Note: Person-r. bullying, Person-related bullying; Work-r. bullying, Work-related bullying. Reported paths are standardized parameter estimates.

^aThis parameter is fixed in the model, so no *p*-value is available.

p* < .05; *p* < .01; ****p* < .001.

the Sobel (1986) test on appropriate unstandardized coefficients. Results indicated that bullying indeed mediated the relationship between job demands and PTSD symptoms ($Z = 4.32$; $p < .05$), which was in line with Hypothesis 5. To increase our confidence on the latter result, we also ran bootstrap analysis, which – differently from the Sobel test – does not rely on the assumption of a normal sampling distribution (Preacher & Hayes, 2008). To this end we obtained appropriate factor scores from Model 2 in LISREL and sent them to the SPSS macro developed by Preacher and Hayes (2008). Results (reported as unstandardized coefficients) indicated that the total effect of job demands on PTSD symptoms (total effect = .60, $t = 10.31$; $p < .01$) became nonsignificant when bullying was included in the

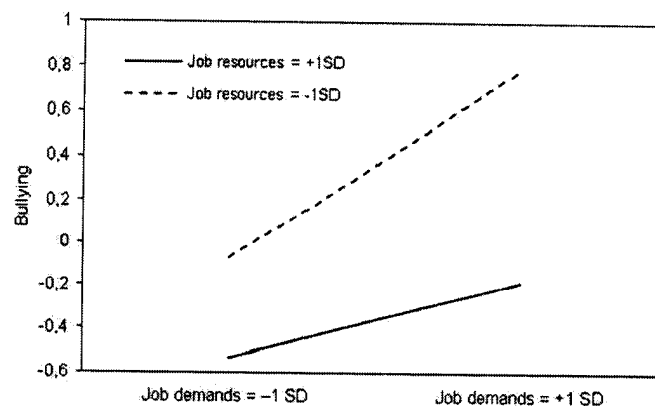


Figure 2. Simple slope analysis for the moderation of job resources on the relationship between job demands and workplace bullying.

model (direct effect of job demands = .07, $t = 1.36$; *ns*). Furthermore, the analyses revealed that the indirect effect of job demands on PTSD symptoms (i.e., the difference between the total and direct effects) was significant, with a point estimate of .50 and a 95% BCa (bias-corrected and accelerated) bootstrap confidence interval of .41 to .60.

Discussion

The current study was designed with the main purpose of testing a comprehensive model of bullying including three unique aspects, namely the consideration of work environmental and personality factors; examination of both traditional stressors and buffering resources; and the inclusion of PTSD symptoms as a possible consequence of bullying-related victimization.

We found that personality and work–environmental factors were independently related to bullying, suggesting two possible different paths to the workplace victimization. As far as personality is concerned, building on previous research (e.g., Bowling et al., 2010) we focused on neuroticism and found that the higher the level of this disposition, of which one of the main characteristics is emotional instability (Warr, 2007), the higher the frequency of the reported bullying. Thus, independently of the characteristics of the work environment, neuroticism may directly contribute to bullying. For example, neurotic individuals may behave in such a way to actively produce conflicts that may cause them to be aggressed by others (Zapf & Einarsen, 2010).

However, the results of the present study strongly suggest that personality is not a sufficient factor for an understanding of bullying. A reformulation and test of the work environment hypothesis (Hauge et al., 2007) according to the principles of the job demands–resources model of work stress (Bakker & Demerouti, 2007) supported the view that psychosocial characteristics of the job (i.e., job demands and job resources) are directly related to bullying over and above neuroticism. According to the job demands–resources model, job demands have the potential to activate negative arousing experiences at work and may, in the longer run, induce health impairment process (Schaufeli, Bakker, & Van Rhenen, 2009). Workplace bullying could be an interpersonal correlate of this process, in that negative arousing experiences at work and stress reactions may predispose individuals to involvement in interpersonal conflicts which may then escalate into bullying. In line with this interpretation, we also found that a job resources factor made up of promotion prospects, co-worker support and autonomy was negatively related to bullying and buffered the job demands–bullying relationship. This is to be expected, since the investigated resources provide protection from the arousing effect of job stressors and thus prevent individuals' experiencing the hypothesized preconditions of bullying. Overall these results further support the view of bullying as a strain phenomenon.

We also found that bullying was strongly related to PTSD symptoms and that bullying mediated the job demands–PTSD symptoms relationship. These findings are original for two reasons. First of all because previous studies on the relationship between bullying and PTSD symptoms (e.g., Balducci et al., 2009) only focused on non-organizational samples (usually clinical samples) of victims. Secondly, a model including a path from working conditions to bullying and from bullying to PTSD

symptoms, where bullying plays a mediating role, has not been previously explored. Our analyses provided evidence for this path, and thus for the plausibility of Leymann's (1996) idea that interpersonal conflicts at work that are related to poor working conditions may lead to bullying, and from bullying to traumatic stress reactions.

Of course we cannot resolve the complex issue of the appropriateness of PTSD diagnosis as a consequence of bullying, which is related to the conceptualization of bullying as an overwhelming traumatic event. However, bullying seems to have indeed the potential for being a traumatic event (Mikkelsen & Einarsen, 2002). To further investigate this issue in our data, in separate analyses (not reported here) we tried to control for participants' exposure to other traumatic events. Specifically, on the basis of an item included in the questionnaire, we split our sample into two subgroups, differentiating workers who over the last year experienced ($n = 117$) versus did not experience ($n = 476$) a traumatic event (e.g., death of the spouse, severe personal illness, divorce) scoring higher than 50 on the Social Readjustment Rating Scale (Holmes & Rahe, 1967) – and refitted our final model of bullying (see Figure 1) on the latter subgroup. Bullying was still strongly related to PTSD symptoms and played a mediating role on the job demands–PTSD symptoms relationship. These results provide further evidence for the traumatic potential of bullying, which perhaps is related to its repetitive nature and prolonged duration.

Study limitations and implications

The most important limitation of our study is that it was based on a cross-sectional design. Longitudinal studies in the work stress area (e.g., De Raeye, Jansen, van den Brandt, Vasse, & Kant, 2008; Schaufeli, Bakker, & Van Rhenen, 2009) do show that organizational factors such as role conflict and role ambiguity have an influence on interpersonal conflicts and health outcomes, so the path from job demands to PTSD symptoms through bullying is plausible. However, there is a strong need for more longitudinal research in this area.

A second limitation is that the data were self-reported, which raises the issue of common method variance. However, other methods, such as observer ratings of working conditions, may be equally affected by bias (Spector, 2006). For example, peer nominations of bullying as used by Coyne et al. (2003) may only capture bullying behaviors that are overt in nature, which may be the minority. Furthermore, by including neuroticism (i.e., negative affectivity) in our model, we considered a crucial source of common method bias (Watson & Pennebaker, 1989).

A third important limitation of the present study is its lack of generalizability. We have focused on employees of a public administration agency in Italy. So it is to be seen in future research whether the present findings generalize to other types of jobs and occupational sectors.

As far as implications are concerned, the results of the present study suggest that management interventions aiming at controlling critical job demands and reinforcing job resources seem to be useful means for avoiding interpersonal conflicts and bullying (see also De Raeye et al., 2008) and their extreme consequences. Furthermore, training employees on conflict management may also be useful, particularly for those with high potential to become targets of bullying.

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EXHIBIT

A27

The effect of stress on learning in surgical skill acquisition

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Abstract

Background: An excessive level of stress and anxiety in medical education can have a negative impact on learning. In particular, the interaction between attending surgeons and trainees in the operating room could induce stress on trainees that is counterproductive, especially if the teaching style or feedback is unduly harsh or critical.

Aim: To characterize the effects of stress resulting from attending–trainee interaction during surgical skill acquisition.

Methods: Forty medical students learned to perform the FLS pattern-cutting task for the first time in one of four scenarios. In the control condition, no mentor was present. In the three experimental conditions, participants were observed, encouraged, or criticized by an expert surgeon.

Results: Task performance, as well as physiological and subjective indicators of stress, were measured. Taking both speed and accuracy into account, participants who were criticized performed the worst on the task, and those who were encouraged performed best. Physiological and subjective measures indicated that the criticized participants experienced the highest level of stress and anxiety.

Conclusion: Even though providing constructive criticism to trainees is inevitable during the course of teaching, an exceedingly critical and negative mentoring style by attending physicians could be detrimental to trainees' acquisition of surgical skills.

Introduction

The literature on stress and the effects of a stressor on learning and performance is rich and covers a wide range of situations (Tomaka et al. 1993, 1997; Kelsey 1999, 2000; Blascovich et al. 2001, 2004; Schneider 2004; Gildea et al. 2007; Schneider 2008; Seery et al. 2010; Schneider et al. 2012). Stress is a process that begins with an evaluation (appraisal) of an impending stressor (Lazarus & Folkman 1984; Lazarus 1999). Stress levels can range from *challenge* to *threat*, based on an evaluation of how relevant the situation is to personal goals, values and well-being, relative to how many resources there are to cope with the situation (Schneider 2004, 2008). At the level of challenge, the situational relevance is deemed to be proportionate to coping resources; while at the threat level, the coping resources available are far less than situational demands and relevance.

Studies have shown that evaluations of threat increase heart rate (HR) and blood pressure (BP) (Allen et al. 1991; Blascovich & Tomaka 1996; Blascovich et al. 2003). For example, one study examined the stress-buffering effects of pet dogs compared to friends. As expected, systolic BP and pulse rate were highest in the presence of friends and lowest in the presence of pet dogs. Compared to friends, pet dogs are non-evaluative social beings and reduced the threat of the stressor. Another study examined appraisals in response to mental math (Tomaka et al. 1993). Compared to threatened

Practice points

- Interaction between attending and trainees is a stressor for the trainee regardless of how encouraging the attending's feedback may be.
- Overly negative criticism, to the point of being perceived as threat-like, is detrimental for learning.

participants, challenged participants had greater pulse transit time (the time for blood to travel from the heart to a peripheral site; inverse to BP) suggesting greater vasodilation. In other words, challenged people should have lower HR and BP stress responses than threatened people.

In the medical domain, a study examined residents' stress responses to trauma situations (Harvey et al. 2012). Low- or high-stress trauma scenarios were presented, and stress levels and performance were assessed. The high-stress scenario evoked greater reports of stress and lower performance on potentially life-saving procedures. Another study found that paramedics working in stressful clinical scenarios performed worse on drug dose calculation tests (LeBlanc et al. 2005).

In addition to detrimental effects on medical performance, stress may also affect the learning of medical skills. In particular, medical education and residency training, especially in the surgical specialty, has long been known to be a

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stressful experience. Interaction with clinical faculty has been identified as a major source of stress for medical students and residents. Among residents and medical students, the perception of being “abused” is common (Mavis et al. 2014), with 50–85% of students claiming they have experienced abuse during training (Dyrbye et al. 2005). A study of third-year medical students’ perception of mistreatment found that verbal abuse was most reported (85%) (Sheehan et al. 1990). Examples included being shouted at, treated rudely, humiliated, and sworn at. A study of Japanese medical residents showed similar rates of overall reported abuse, with surgical rotations being the most frequent site of occurrence (27.6%) (Nagata-Kobayashi et al. 2009). However, the effects of stressful attending–resident interactions on learning and performance is not clear.

The purpose of this research is to examine the effects of different types of interaction in the attending–student relationship on the acquisition and performance of laparoscopic surgery skills in the skills laboratory. We hypothesized that a challenge-like (encouraging) instruction set would lead to less subjective stress, a more salubrious physiological pattern, and better task performance compared to threat-like (evaluative/criticizing) instructions or the control (independent) or observed (neutral) conditions.

Method

Participants

Participants were first- through fourth-year medical students from the Wright State University (WSU) Boonshoft School of Medicine. A total of 43 participants were recruited, with no known visual, cognitive, or motor impairments that would prevent them from taking part in the experiment. Three participants were excluded; one was not able to perform the task and two received incomplete instructions. The 40 participants were 55% female, with a mean age of 26.1 years ($SD = 2.6$). None had any prior experience with surgical simulation, or with the task used in this experiment. The research protocol was approved by the WSU Internal Review Board, and all participants gave written informed consent.

Task

A laparoscopic pattern-cutting task was used (“Revised-Manual-Skills-Guidelines-February-2014.pdf,” n.d.). The pattern-cutting task is one of five basic laparoscopic surgery tasks in the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) Fundamentals of Laparoscopic Surgery (FLS) training system. The task consists of cutting out a circle that has been drawn on a piece of 10.16 cm \times 10.16 cm square gauze, which has been suspended inside an FLS training box (Figure 1). Participants were required to cut along the outline of the circle using laparoscopic graspers and scissors that are inserted into the training box. Performance was scored based on time to task completion and accuracy of the cut.

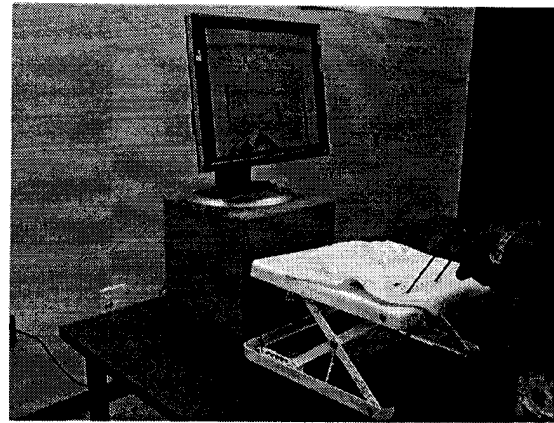


Figure 1. FLS box displaying pattern-cutting task. A piece of mesh measuring 10.16 cm \times 10.16 cm with a circle drawn on it was suspended inside the box. Subjects used laparoscopic graspers and scissors to cut along the outline of the drawn circle while watching the task space on a monitor positioned in front of them. The objective of the task was to cut out the circle as quickly and as accurately as possible.

Procedure

Data were collected for each participant in a single session. Upon arriving, the participant was taken to a briefing room, shown a 2-min video demonstrating how the pattern-cutting task is performed, and instructed on the use of the laparoscopic tools. The participant was then given 5 min to practice performing the task itself.

The participant was then taken into a testing room to complete the block of trials, which lasted one hour or until 10 trials of the pattern-cutting task had been completed, whichever came first. Some participants (12 out of 40) were not able to complete all 10 trials within the hour. However, all participants were able to complete at least six trials. For each trial, time to completion was recorded. Timing for each trial began when the participant first grasped the gauze with the laparoscopic tool, and ended when the circle was completely cut out and free of the remaining gauze.

Before the trial block began, an inflatable cuff was attached to the participant's right upper arm for measuring mean arterial pressure (MAP) and IIR. Two surface electrodes were attached to the inside of the participant's left forearm to measure skin conductance. Physiological measurements were taken at four instances during the experiment, each taking 2–3 min to complete. The first measurement was to establish baseline and occurred just before the block of pattern-cutting trials began. Measures included MAP, HR and skin conductance. A saliva sample was also taken for baseline cortisol. At the same time, a six-item abbreviated version of the State-Trait Anxiety Inventory (STAI) (Arora et al. 2010b) was administered to assess participant anxiety.

The second round of measurement was taken 20 min into the experiment, or after the fifth trial, whichever came first. This time point was chosen to capture any peak rise in cortisol concentration, which typically occurs 20–30 min after stressor

onset (Kirschbaum et al. 1992; Robins et al. 2009). The third round was taken 40 min into the experiment, or after the eighth trial, whichever came first. The fourth round was taken after the last trial, which was either the 10th trial or after an hour had elapsed, whichever came first.

Experimental design

This study utilized a between-subject experimental design. The 40 subjects were assigned to one of four groups (Control ($n=10$), Observed ($n=10$), Encouraged ($n=10$), Criticized ($n=10$)) in order as they responded to the solicitation for participation. In the *Control* condition, participants simply completed the block of trials as described in the procedure above. In all other conditions, participants were led to believe an expert surgeon was evaluating them. The ostensible expert surgeon was portrayed by a professional actor. Although the actor was present in the testing room upon participants' arrival, he was not introduced to participants until after the baseline measurement was complete. The actor was introduced as an expert in laparoscopic surgery who would be doing the evaluation. Throughout the trials, the actor interacted with participants in a manner consistent with the experimental conditions – Observed quietly, Encouraged the participant, or Criticized the participant.

In the *Observed* condition, the “expert surgeon” maintained a silent and neutral demeanor as he observed the participant performing the task. In the *Encouraged* condition, the actor provided positive verbal feedback and projected an encouraging and nurturing demeanor. For example, he said “Nice job. Keep up the good work.” In the *Criticized* condition, the actor critiqued the participant harshly and was critical and condescending. For example, he stated sarcastically, “Nice job. I think you just killed our patient.” The observational, encouraging, or critical demeanor was maintained regardless of how participants performed. Since performance was to be compared across conditions, the feedback contained no instructive content that might improve task performance.

Participants were assigned to their group based on the order in which they were scheduled for participation in the study with 10 participants in each group. The control condition was completed first, followed by the Observed, then Encouraged, and lastly Criticized group. The main reason for assigning subjects in this manner, rather than a purely random assignment, was that the experiment involved the deception that they were being evaluated by an expert surgeon. The experimental design relied entirely on participants being naïve to the purpose of the study and not discussing the protocol amongst themselves. Therefore, conditions were completed according to their increasing level of expected psychological impact. At the end of the experimental session, the participant was debriefed. It was then disclosed that this study was examining the effects of stressful scenarios and that the expert was actually an actor.

Physiological parameters selection

Measuring stress responses has been accomplished using both physiological and subjective markers. For the current experiment, physiological parameters were selected based on

previous research showing that they have predictive validity. HR, BP, skin conductance, and cortisol have all indicated increased stress responses (Arora et al. 2010a). Arora et al. developed the Imperial Stress Assessment Tool (ISAT) (Arora et al. 2010b) which combines three objective and subjective stress response measures: salivary cortisol, HR monitoring, and self-reported stress levels by means of an abbreviated STAI. This tool reliably and validly assessed intraoperative stress levels of experienced surgeons while performing surgery (Arora et al. 2010b). We used salivary cortisol, skin conductance, HR, BP, and the abbreviated STAI test as well. However, differences in skin conductance were not analyzed because a preliminary examination of the data showed that changes in skin conductance values were constantly changing and would not be meaningful as a discrete measure.

Results and discussion

Physiological Measurements

To verify that there were no systematic differences between the groups at baseline, a one-way (four conditions) ANOVA was performed on each physiological measure, with an alpha of 0.05 used for all significance tests. There were no significant differences among conditions for any baseline physiological measures. That is, participants were similar in physiological and subjective metrics at baseline across the four conditions. Therefore, subsequent differences between the four groups can be attributed to the experimental condition. To assess reactivity, difference scores were created for each participant by subtracting his or her baseline from his or her task responses.

Both Condition (Control, Observed, Encouraged and Criticized) and Time-Point (difference from baseline as measured at 20-min, 40-min, and post-experiment) were analyzed using a two-way mixed model ANOVA with repeated measures on Time-Point for each physiological measure. For those measures with a significant main effect, a *post-hoc* Tukey HSD was performed. Means and standard deviations for the four conditions at each time point are given for each measure in Table 1.

The difference scores for the STAI are shown in Figure 2a. Differences greater than zero indicate that participants' level of anxiety increased above baseline. There was a significant main effect of Time-Point ($p<0.001$), but not Condition ($p=0.39$). The post-hoc analysis showed that scores significantly decreased between 20-min and 40-min ($p=0.02$), and between 20-min and post-experiment ($p=0.004$). All of the groups experienced an increase in anxiety at the 20-min mark. This initial anxiety could be due to learning a new and difficult task, or to simply being part of an experiment. However, after the 20-min mark, STAI scores returned to baseline levels for all but the Criticized group, suggesting that participants were able to acclimate psychologically to performing the task so long as they were not being criticized.

The average differences in cortisol concentration from baseline obtained for each condition are shown in Figure 2b, with higher levels denoting greater stress responses. There was a significant main effect for Condition ($p=0.03$), but not for Time-Point ($p=0.12$). The post-hoc analysis revealed that

J. T. Flinn et al.

Table 1. Unit of measure, *p*-values, and descriptive statistics for the physiological measures.

Measure	Unit	<i>p</i> -Values		Condition	Difference from baseline		
		Cond	TP		@ 20-min	@ 40-min	Post-exp.
STAI	Scale point	0.07	0.006**	Control	1.3 ± 1.8	0.6 ± 1.5	0.5 ± 2.2
				Observed	1.0 ± 1.9	0.0 ± 2.8	0.1 ± 2.8
				Encouraged	1.4 ± 3.4	0.0 ± 2.8	-1.2 ± 3.9
				Criticized	3.5 ± 3.1	2.6 ± 2.6	2.2 ± 2.4
Cortisol	µg/dL	0.03*	0.12	Control	-0.049 ± 0.062	-0.100 ± 0.074	-0.117 ± 0.082
				Observed	0.006 ± 0.100	-0.015 ± 0.095	-0.008 ± 0.100
				Encouraged	0.033 ± .102	-0.021 ± 0.124	-0.001 ± 0.120
				Criticized	0.033 ± 0.084	0.045 ± 0.137	0.048 ± 0.136
MAP	mmHg	0.12	0.37	Control	0.5 ± 6.1	0.7 ± 10.4	0.3 ± 4.6
				Observed	6.6 ± 7.0	6.8 ± 5.3	5.0 ± 8.7
				Encouraged	1.6 ± 5.6	3.1 ± 5.7	0.1 ± 8.2
				Criticized	3.2 ± 12.6	8.1 ± 9.5	8.4 ± 8.5
HR	bpm	0.39	0.80	Control	-0.2 ± 7.2	-1.2 ± 5.5	-1.5 ± 7.6
				Observed	3.0 ± 9.0	2.6 ± 13.9	4.1 ± 13.3
				Encouraged	3.8 ± 13.7	4.0 ± 15.4	5.0 ± 13.8
				Criticized	7.0 ± 10.9	7.3 ± 12.2	8.2 ± 13.0
SC	µSiemen	N/A	N/A	Control	3.61 ± 9.88	6.29 ± 10.97	7.78 ± 16.02
				Observed	2.58 ± 9.47	7.36 ± 12.46	8.34 ± 10.61
				Encouraged	8.54 ± 18.90	10.27 ± 18.81	10.78 ± 16.30
				Criticized	-0.01 ± 24.32	3.67 ± 26.84	3.87 ± 24.26

Descriptive statistics are the mean ± 1 standard deviation by the condition and time point.

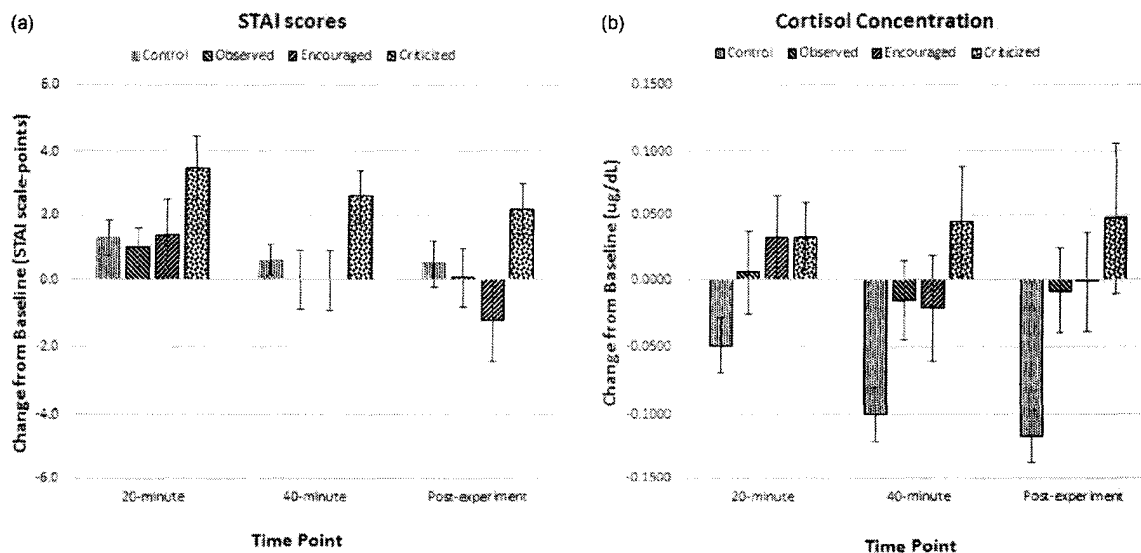
p* < 0.05; *p* < 0.01.

Figure 2. Differences from baseline scores as a function of time of measurement and condition. (a) State-Trait Anxiety Inventory (STAI) scores show an initial increase in anxiety level for all subjects, but only the Criticized group's anxiety remained elevated at 40 min into the experiment and after the conclusion of the experiment. (b) Significantly higher cortisol level above baseline, as an indicator of higher stress response, was found in the Criticized group. Error bars are ± 1 standard error of the mean.

the difference from baseline in cortisol concentration was significant for the Control and Criticized groups only (*p* = 0.02). Cortisol concentration increased following baseline for participants in the Criticized group whereas it decreased for those in the Control.

The average differences in MAP and HR are shown in Figure 3. Although increases in both HR and MAP were

generally highest for the Criticized group, no significant group differences were found.

Performance measures

Score

In the FLS testing system, performance scoring is based on how quickly the circular pattern is cut from the gauze, with a

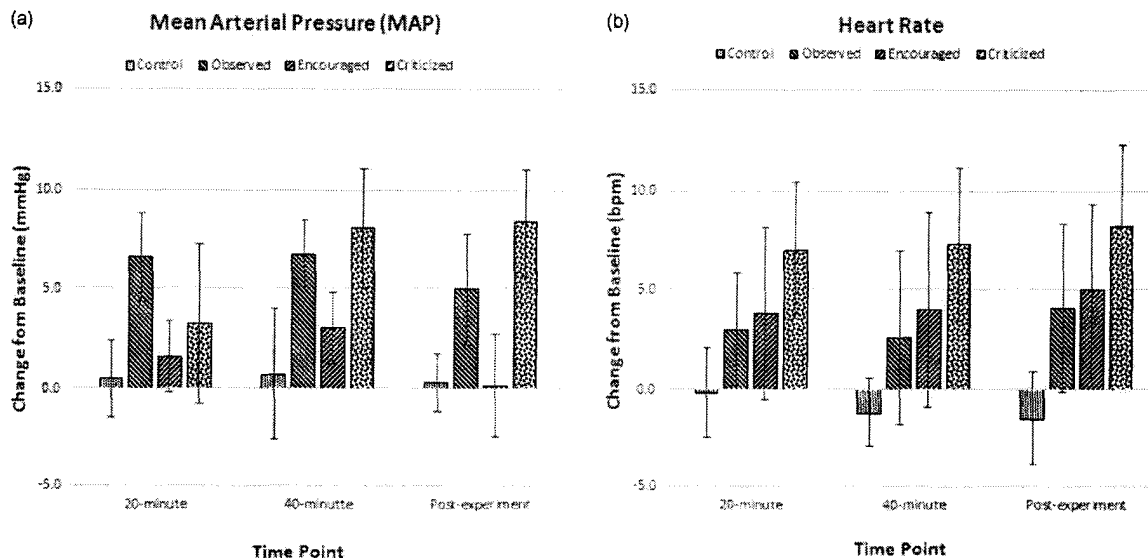


Figure 3. Differences from baseline score as a function of time of measurement and condition for (a) MAP, and (b) heart rate. Error bars are ± 1 standard error of the mean. No significant differences were found amongst the four groups.

penalty imposed based on the amount of error. Higher scores denote quicker cutting with less error. Score calculation is proprietary, used here with permission from SAGES.

The average FLS score was calculated for each trial. Then, for each participant, trial scores were grouped as the score on the first trial, the score on the last trial, and the mean score for all of the trials in between (Figure 4). These scores represent the early, late, and middle stages of the Learning Curve. Scores were analyzed using a two-way mixed ANOVA with a between-subjects factor of Condition and a within-subjects factor of Learning Curve (First-Trial, Between-Trials, or Last-Trial). A significant main effect was found for both Condition ($p=0.03$) and Learning Curve ($p<0.001$), with no significant interaction ($p=0.07$). A post hoc analysis showed significant differences between all points on the Learning Curve, with scores increasing over the course of the experiment. For Condition, the post-hoc test showed a significant difference between the Criticized and Encouraged groups only, with the Criticized group having the lowest overall scores.

General discussion

The STAI and physiological measures were used to ascertain stressor responses. Some degree of elevated reactivity was expected for all conditions, since all participants were being scrutinized while learning a new and difficult task. We expected that observation and criticism would evoke heightened stress responses relative to a control and encouraged group. It was hypothesized that the criticized group would appraise the negative feedback as a threat rather than a challenge, and would exhibit more indications of anxiety and physiological stress responding than the other groups, and perform worse on the experimental task. In fact, the criticized group did score lower than all the other groups throughout the trial block. Furthermore, the increases from the baseline STAI and physiological measures for the criticized group were generally larger

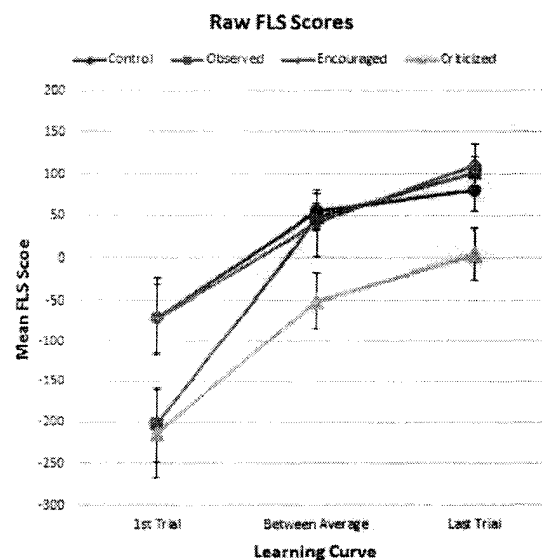


Figure 4. Mean raw FLS scores as a function of condition and learning curve. Error bars are ± 1 standard error of the mean. The overall performance scores for the Criticized group were significantly lower than those for the Encouraged group.

than those for the other groups, and were always larger than the control group for all measures and across time points. Although not always statistically significant, this consistent trend suggests that we may have suffered from low statistical power given this sample size. There were 40 participants altogether, but they were split equally into four experimental groups. In addition, the task was intentionally difficult in order to avoid ceiling effects in learning and performance, but perhaps at the cost of a wider range of individual differences.

Nevertheless, the overall trends in the data suggest that the criticized group was the most "stressed" and that the control

group was the least, with the observed and encouraged groups falling somewhere in between. The presence of a putative expert evaluator acted as an additional stressor among the observed, encouraged, and criticized participants, and the degree to which participants were affected depended on the way in which these stressors were likely appraised, given the manner of interactions between the evaluator and the trainee.

Performance-wise, the observed and criticized participants initially scored lower than those in the control and encouraged groups. After the first trial, however, the observed group's performance increased to a level similar to that of the control and encouraged groups. This may be because participants in the observed group did not know what to expect from the observer at first, other than that they were being evaluated. After the first trial, however, in the absence of any negative commentary, it appears participants had deemed the observer to be benign. This pattern of results suggests that it is not the case that encouragement improves performance, but that criticism impairs it. This would imply that productive teacher-student interaction does not depend on any particular instructional style so long as it is not negatively critical to the point of being appraised as threat-like in nature. Future research may investigate the threshold for threat in stress appraisals to allow for more effective teacher-student interactions.

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